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Harvard Medical
ALUMNI BULLETIN

The Class of 1998 made HMS history with 53 percent women. Photo by Larry Lawfer

Half a century earlier, the Class of 1949 made history when it admitted 12 women.

Inside HMAB

Harvard Medical
ALUMNI BULLETIN

It is a truth universally acknowledged that Harvard was unconscionably slow to admit women students—and slower still to welcome them. For the first 23 of the last 50 years, women consistently made up only 10 percent of the student body, give or take a point or two. Then, with the class that arrived in 1968 the percentage increased. If there was an explicit change of policy, it wasn't commented on in the *Bulletin* at the time. The subsequent statistics nonetheless reveal a steady commitment to parity between the sexes, achieved this year with an entering class that has more women than men.

The brief history of women at HMS so far appears to have had four phases: flat exclusion lasting to the end of the First World War; surreptitious importation between the two world wars (when Alice Hamilton and a few others were grudgingly appointed to faculty rank); defensive toleration until 1968; and after that a period of normalization. This year's statistical milestone marks no real change in the 27-year process of normalization, but is a sign that it has become irreversible.

HMS, like Ebeneezer Scrooge, has undergone a transformation of character. The old sinner has reformed, but the challenges that remain are daunting indeed and will be a test of institutional resolve well into the next century. The task is, in essence, to make certain that women given the opportunity to complete a medical education at Harvard are then given postgraduate clinical and academic opportunities comparable to those of their male contemporaries. This will require us to recognize that women are not just men who sometimes get pregnant. For women to succeed, their careers must be organized differently from men's, and men will have to assume responsibilities that they have long eluded in the conventional division of family labor.

This issue of the *Bulletin* offers the reflections of women in the Harvard medical community who have been participants in this historical process. It also is a result of the efforts of the *Bulletin's* three excellent women editors. I would particularly like to acknowledge the contributions of Associate Editor Terri Rutter, whose work is reflected in the time line in the center of this issue, as well as in many of its articles.

William Ira Bennett '68

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Letters

Internet Interaction

So, you requested response. This I will do, though I would hope that the *Bulletin* never becomes a solely electronic phenomenon. I do wonder whether this will become an acceptable means of a letter to the editor.

In that capacity, I would like to further extend my congratulations on "The Writers Among Us" issue (Summer 1994). No one has mentioned Ethan Canin, but I found his story, "Angel of Mercy, Angel of Death," to be a marvelous piece. As he is in San Francisco, I called and told him so. I also bought his first book, *Emperor of the Air*—which coincidentally contains a great story quite similar to Klee's "The Curious Cure" in your current issue (Winter '95). In Canin's tale, the dying husband arranges before his demise that a puppy be delivered to his widow on Christmas, and the puppy similarly provides the boost the widow needs to get through.

I would also say that the *Bulletin* is by far my favorite alumni magazine—keep up the great work!

John Dorman '67

Note: This is 1 of 27 e-mail responses we received and our first Letter to the Editor! Address e-mail letters to bulletin@warren.med.harvard.edu. The old-fashioned ways of writing to us still work, too: 25 Shattuck St., Boston, MA 02115; fax: (617) 432-0013.

"The reports of my death are greatly exaggerated."

Sometimes things happen that you expect (or hope) will never happen to you. Such an event led to Mark Twain's famous quotation.

Friday morning my wife, Enid, received a phone call from my HMS '44 classmate Bob Scully. "Enid," he said, "I'm so sorry to read of Lew's death in this month's *Alumni Bulletin*." Enid, like Bob, is a pathologist and like all pathologists her middle name is equanimity. "Well," she answered, "he was breathing this morning. Frankly, he didn't look any different than he did yesterday."

Scully countered, "I thought there was something funny, the note said he was survived by his widow, Sylvia." "Really," Enid replied. "Maybe there are skeletons of which I'm not aware."

The importance of this was emphasized when we got home and found a recording on our phone answering device from a distraught Sydney Gellis '38, my hero and mentor of many years. "Enid, I just read the terrible news about Lew, and incidentally, I think it's poor taste to leave his voice on the answering machine."

After calling him and hearing the distress in his voice, she said, "I'll let you speak to him." I got on the phone and told him this was a very long distance call and it was very hot here.

On Tuesday I received a call from the *Bulletin's* editor. She apologized for the error and said she was sorry, but did not make clear whether she was sorry for the notice or that I was alive or both. I assured her that my mother's name was Mary and my father's name was Joseph and that he was a carpenter. Therefore she need not worry.

I am confused as to whether this was wishful thinking or if the school anticipated a large trust.

Now the truth is that life and being alive are philosophical concepts. When Enid related this conversation, I immediately went to the EEG lab where squiggles were reported. My pulse ox is respectable and my EKG shows electrical discharge. Nonetheless, if I am dead, legally that is, please notify our class agent, Chet d'Autrement.

Lewis Barness '44

I have just received a copy of Lewis Barness's letter of February 22, 1995.

On thinking about the Barness affair, I am tempted to suspect that the whole thing has been his attempt at humor. Barness is highly suspect; he will stop at nothing! One example occurred when I was chief of the Outpatient Department at Children's and Barness was a pediatric intern (said to be the oldest intern on record). He called me one afternoon, all excited, asked if I had ever seen Stevens-Johnson disease in a six-month-old infant. When I said no, he asked me to meet him on the infant's ward and he'd show me a patient with the disease. I ran up and he was standing by a crib. As I came close to the infant and saw no signs of rash, I turned on Lew, prepared to inflict violence. He said, "Stop! Look at the child's name on the foot of the bed."

Of course, he was named Steven Johnson!

This is only one instance of many in Lew's sordid career. Perhaps the current episode is his way of crying out for help. He needs it.

Sydney Gellis '38

Guns Out of Control?

Marian Wright Edelman's otherwise excellent article about violence to and by children ("Cease Fire: Stopping the War Against Children," Autumn 1994) was marred by factual inaccuracies and unsupported prejudice concerning firearms and their supposed causative relation to her subject.

Factually, her only citation supporting such a proposition was the thoroughly discredited New England Journal of Medicine study purporting to show that it is 43 times more likely that in a household in which guns are owned, a family member will be killed than a justifiable homicide will occur (i.e., that an intruder will be killed). As

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Kleck (G. Kleck, *Guns and Violence in America*, 1991) and others (B. Centerwill, article in *American Journal of Epidemiology*, December 1991; T.R. Gurr, *Violence in America*, 1991) have shown, this study fails to take into account that, in the vast majority of cases when an armed homeowner confronts an intruder, the intruder flees and no one is killed. Kleck's and other studies have shown that such events occur more often than do criminal use of firearms (650,000 versus 580,000).

Further, the *NEJM* study included suicides, which at least arguably would have occurred without the presence of a firearm and by using households as the unit of reference included that subset of the entire population most prone to reckless and dangerous behavior (i.e. young males).

Accordingly, the cited study in no way supports the proposition that guns cause violence nor does it support the proposition for which it is usually cited—that guns do not protect people from violence. Kleck and others have disproved the latter proposition and the former must be rejected by any rational analysis.

Guns are inanimate objects. They are not good or evil in themselves nor are they malevolent or willful. While prehistoric man assigned such attributes to inanimate objects, rational analysis has long since accepted that inanimate objects are just that—and that value judgments regarding how such objects are used must be directed toward the user not the object.

The only valid question that can be asked about guns, as in the case of all tools, is whether they are useful when used properly and whether this utility outweighs the risk of being used improperly. Since guns are in fact used effectively in 83 percent of the cases where a victim resists with a gun (criminal is killed, surrenders or flees) and are more effective in preventing death or serious injury to the potential victim than any other means, including nonresistance, Kleck concludes that the view that gun ownership has no social benefits beyond the minor value of recreational use is not in accord with the facts; guns save lives and restricting gun ownership by law-abiding citizens will actually cost lives.

Accordngly, it has not been established, as Edelman asserts, either (I) that guns are per se bad or (II) that guns per se cause violence, whether among or against children or in the population as a whole. Emotion and belief is not a substitute for facts and scientific analysis.

John C. Richardson
Harvard Law School, 1960

To Gordon, With Thanks

Browsing through the Autumn issue of the *Harvard Medical Alumni Bulletin*, and learning about "dropping our pilot," I'm prompted to tell how much pleasure Gordon Scannell '40 has brought by enduring editorial taste and skill these many years.

Amid the dross regularly stuffed into our mailbox by some devilish counterpart of the sorcerer's apprentice, comes every so often a breath of fresh air...the *Bulletin*! Well above the fray, he has consistently given all of us the gift of thoughtful discourse on the multitude of topics relating to the healing art. My warmest thanks and congratulations.

Bert Bemison '41

P.S. As I relaxed with a pre-dinner demi tasse in Vanderbilt Commons, circa 1938-40, an upper classman would frequently be at the Steinway skillfully playing upbeat and popular songs of the day. Occasionally he would be joined by a partner and, without a shred of sheet music of any sort, they would plunge into fascinating, four-hand improvisations. I have often wondered who they were and what ever happened to them.

Pulse

Margaret Hamburg

photo by Barbara Steiner

Women Celebrated

The list of attendants to the celebration of 50 years of women in medicine at Harvard Medical School read like a page from a who's who directory. (In fact, photos of several of the celebrated ones appeared in the society pages of the *Boston Globe* a few days later.) On March 17 and 18, HMS brought its first women students home to sit and talk with its current, while in symposia and workshops, older female faculty discussed the history of their academic trials and young female faculty gave fresh fire to these tales of struggle, but also gave hope for the future.

The celebration began on Friday evening as over 350 people, predominately women, were wined, dined and feted in the elegantly transformed atrium of the Warren Alpert Building. Post-prandial speakers were the esteemed Hamburg family—Margaret '83, commissioner, New York City Department of Health; and her parents, Beatrix, president of the William T. Grant Foundation; and David, president of the Carnegie Corporation of New York—who, with help from their moderator, television commentator Ellen Hume, looked at "Medicine as a Family Affair."

A full-day symposium on Saturday began with a discussion of the Women's Health Study and the Women's Health Initiative. The women's health theme was continued later in the day with an-indepth examination of women's cancers. Priscilla Schaffer, professor of microbiology and molecular genetics; Myles Brown, assistant professor of medicine; and Margaret Shipp, associate professor of medicine, discussed the recently initiated Women's Cancers Program at the Dana-Farber Cancer Institute, which will target the cancers most proliferative in women: breast, gynecological and reproductive, and lung.

Regina Markell Morantz-Sanchez, professor of history at University of Michigan, traced the legacy of women physicians to their foremothers, who practiced medicine from within the ideology of the Victorian cult of motherhood [see page 16]. And Judith Rapoport '59, chief of child psychiatry at the National Institutes of Mental Health, encouraged a lunch-time crowd to be "Female, Flexible and Fearless."

The most raucous and yet most telling panels during the day-long event were the one with students, alumnae and faculty and the other on the "Future Career Opportunities for the New Generation of Physicians and Scientists." One of the school's first, Racquel Cohen '49, director of the Children's Center, Office of the State Attorney in Florida, said she had wonderful experiences while a student at HMS. Student Martha Penglase '97, however, reminded everyone that those wonderful experiences come at a heavy price—she is currently $50,000 in debt with two more years to go.

Illonna Rimm '83, assistant professor of pediatrics, had a fine time in medical school, but when she began her ascent in the ranks as an investigator, difficult encounters with her male colleagues on higher rungs left her with quite a different feeling. She gained strength, she said, when her husband gave her a present: a handball inscribed with the names of the faculty members who were making life hard for her: "Go play hardball with the big boys," he told her. And she did.

The final panel of the day brought together some of HMS's most established women—a few of whom began

Maria Alexander-Bridges and Gwendolyn White

photo by Barbara Steiner

their medical careers among a virtual sea of male faces. Lynne Reid, S. Burt Wolbach Professor of Pathology and one of the first women here, introduced another from the original few, Mary Ellen Avery, Thomas Morgan Rotch Professor of Pediatrics. Avery is famous for her work on respiratory distress of prematurely born infants, whereas Reid is known for her work on the pathology of chronic lung disease.

"When I first came here," said Reid, "we used to be introduced as 'the lady of the first breath and the lady of the last gasp'."

Patricia Donahoe, Marshall K. Bartlett Professor of Surgery; Joanne S. Ingwall, professor of medicine; and Barbara McNeil '66, Ridley Watts Professor of Health Care Policy and professor of radiology, also had advice for the next generation: above all, have passion and love for medicine and for your work.

And, as Donahoe advised, courage: "Have the courage to do what you want," she said. "Choose your career from a deep love for what you want to do; a hunger in the gut that you can't control. Live, eat and drink your profession; don't be afraid to love it out loud."

Martha Troutman '49 and Cliff Barger '43A

photo by Barbara Steiner

Head of International Efforts Chosen

Robert K. Crone, a pediatric anesthesiologist and senior vice president of Project Hope, has been selected CEO of Harvard Medical International, a corporation established to develop and market programs in medical education, research and clinical care in foreign countries. He will also serve as HMS dean for international programs and clinical professor of anesthesiology at Children's Hospital.

By exporting its expertise, HMS seeks not only to help other countries improve their education, research and patient care, but also to enhance revenues for its own mission. "We want to generate resources for the school by doing things consistent with our mission and our sense of how to carry it out," explains David Bray, executive dean for administration.

One important focus for HMI is to help design and manage medical facilites, such as teaching hospitals, medical schools and private hospitals. Harvard faculty throughout the affiliated hospitals will be recruited as consultants, visiting faculty and project leaders to do such things as develop and teach for continuing education and residency programs, and set up quality assurance systems. Programs are in development in the Asian Pacific, the Middle East and in Latin America.

Crone had been senior vice president for medical operations for Project Hope since 1992, although he had begun volunteering for this nonprofit health foundation in 1980 when he was at Children's Hospital in Boston. He completed an internship and residency in pediatrics and anesthesia at MGH, before moving across town to Children's, where in 1980 he became director of the intensive care unit. He left in 1988 to head the anesthesiology department at the Children's Hospital and Medical Center in Seattle and was

photo by Barbara Steiner

Robert K. Crone

professor of anesthesiology and pediatrics at the University of Washington School of Medicine.

At Project Hope Crone was responsible for all of the medical and health-related programs, mostly in the less developed countries. He handled negotiations with foreign governments and institutions and dealt with the challenge of bridging different cultures—skills he will need for Harvard Medical International.

"Harvard is known for its quality worldwide," says Crone. "The challenge is how do you take the Harvard name and quality and export that."

Vision Without Sight

Some totally blind people, despite an inability to perceive images, are in fact responding to cues from light that regulate the body's circadian cycles. "This study is the first demonstration in humans that eyes carry out a second function," said Charles Czeisler, HMS associate professor of medicine and lead author of the study that appeared in the January 5 *New England Journal of Medicine*.

"In addition to sight, the eyes are part of a completely separate system that keeps our sleep-wake cycle in synch with the rhythm of a 24-hour day," he said. "They are analogous to ears, which control both hearing and balance."

In a preliminary study in the laboratory of Czeisler's Section on Sleep Disorders and Circadian Medicine, researchers tested the effect of bright light in decreasing plasma melatonin concentrations on 11 people who are blind and 6 who had normal vision. The hormone melatonin—thought to act like a natural sleeping pill—is known to be suppressed by light and to increase during the night. The pineal gland secretes melatonin in response to a signal from the hypothalamus's suprachiasmatic nucleus, the circadian "pacemaker."

Though often blindness results in desynchronization of circadian rhythms and thus, sleep disturbances, it was known that some blind people retain their clock-setting functions. The researchers in fact found that in three of the blind people, melatonin concentrations decreased in response to light and that these three, unlike the other blind people tested, were "entrained" to a 24-hour day and didn't have sleep problems. If these three were blindfolded, like those with normal vision, melatonin did not decrease.

This was referred to as "vision without sight" in an accompanying editorial by Robert Y. Moore. These people can "see" nothing, but at least can synchronize their lives to the visual world.

Though sweeping conclusions cannot be drawn from only 11 subjects, Czeisler guesstimates that about 30,000 totally blind people in the United States have this vision without sight. His group is planning a larger study, but in the meantime has devised a test to determine whether the clock-resetting mechanism remains intact. This is important because due to pain or infection, many blind people have their eyes removed and replaced with artificial globes. And because the hormonal system appears to depend on input through the eyes: "Blind people should not consider such surgery until they find out if this mechanism is intact," says Czeisler.

Charles Czeisler

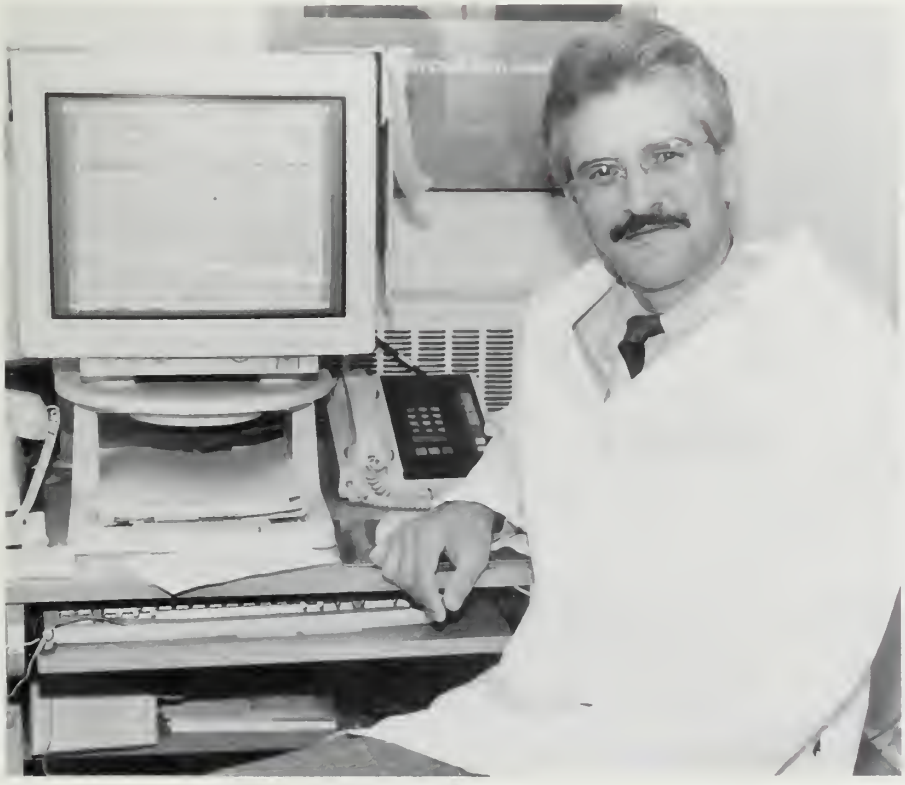


photo by Barbara Steiner

Pulse

Consolidating Med/Peds

Massachusetts General Hospital, Brigham and Women's and Children's hospitals are consolidating their existing combined medicine/pediatrics programs into one collaborative residency, beginning in June of this year.

"Some people call it the return of the old generalist practice programs," said director Larry Ronan '87, instructor in medicine and pediatrics at MGH. "I call it training the new generalists; these are people who can take care of patients throughout the life cycle."

Similar to family practice, the program trains physicians to be responsive to patients throughout their lives, but even more extensively, it provides specialty training in pediatrics. Residents will rotate between the two fields every three months and will spend a half-day each week in a community clinic in Chelsea, Revere or Jamaica Plain.

"It seemed like the most efficent way to provide the necessary training for this field of medicine," said David Nathan '55, head of the Department of Pediatrics at Children's Hospital. "The future of medical education is collaboration."

Health Care Reform Day

Not content to let the health care reform roulette wheel stop, first- and second-year HMS students organized a Health Care Reform Day in December last year, bringing issues debated on a national scale to the medical school arena. Their efforts drew about 200 participants, both students and faculty, and also the attention of a couple guys who do this for real: former governor Michael Dukakis attended and President Bill Clinton sent a letter from his vacation in Honolulu.

"My original hope was to provide a forum where students could discuss issues relating to health care reform that was consistent with how real legislation is created and debated," said Thomas Roberts '97, who holds a degree in economics and public policy and management from the Wharton School of Business. Roberts conceived the idea while lobbying members of

photo by Barbara Steiner

Med/peds resident Matt Davis '94, with Phillip Simon.

Congress on the issues of health care reform as a representative of the American Medical Student Association last year.

Participants debated four resolutions, which were written by students from the group of about 50 who organized the event, and were presented by those who deliberate these issues on a day-to-day basis, including Marcia Angell, executive editor of the *New England Journal of Medicine*; John M Ludden '66, senior vice president for medical affairs at Harvard Community Health Plan; William D. Terry, senior vice president of ventures and research at Brigham and Women's Hospital; and James Sabin '64, division of medical ethics at HMS. Resolutions focused on issues of graduate medical education, health care financing, biomedical research and ethics of rationing.

Like their compatriots in Washington, attendants couldn't agree; the "general assembly" accepted two resolutions and rejected two. "It's clear that when we put our heads together we can really get something accomplished," said Thomas Clancy '97, who moderated the discussions. "But at the same time, we recognize how difficult it can be to reach agreement on some of these issues."

Accepted were the resolutions on graduate medical education and health care financing. The former called for increasing the number of primary care physicians by creating favorable work environments in terms of compensation and loan forgiveness. The resolution's second point was to mandate schools to produce primary care physicians by making accreditation from the Liaison Committee on Medical Education contingent on their establishment of a Department of Primary Care.

The resolution for health care financing called for a single-payer system, which, its authors contend, would be the "best opportunity to provide universal, cost-effective and administratively uncomplicated health care that preserves the autonomy and medical integrity of the patient-physician relationship."

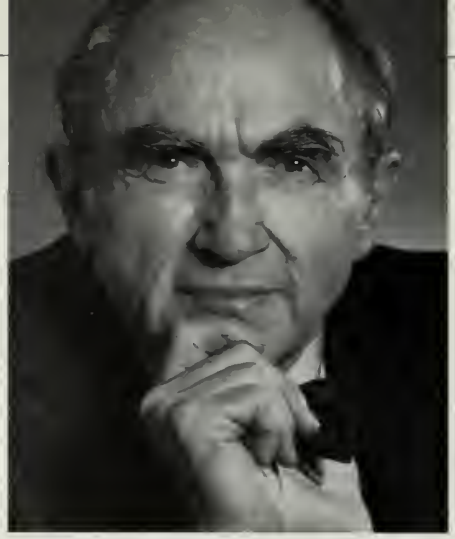
Rejected resolutions called for evaluating the cost effectiveness of new medical technologies and restricting government reimbursement to technologies shown to be cost effective; and a recommendation that doctors act as a "stewards of community resources" in rationing health care.

Dukakis, who provided the keynote address, sympathized with the dissension in the house: "If it were easy folks, you wouldn't be here and I wouldn't be here. We'd have done this a long time ago."

photo by Barbara Steiner

"It is the year 2002. Dan Goodenough has become dean of the medical school and has led the New Pathway to its culmination, the Really New Pathway. Harvard Medical School has become Harvard Medical School for the Arts (HMSA). In place of exams, students express their knowledge of medical science through art. Instead of the National Boards, students write and perform the second-year show. Meanwhile, an embittered Betty Hay, with the assistance of a gang of HST students and other maniacal professors, plot to sabotage the second-year show, *Schwann Lake*, and destroy the Really New Pathway."
—*Schwann Lake* Program

On the Quadrangle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New Chair of the Fund

The new chairman of the Alumni Fund, Cliff Barger '43A, is relishing the renewed contact with former students his duties entail, writing letters to graduates around the world. "As I write these letters, I've been looking back over the years," he comments. "Working alongside students in the lab gave me insights and friendships that are just invaluable."

If he rhapsodizes about students who are now famous or otherwise, they in turn have not forgotten him. In his 50 years of teaching, the Robert Henry Pfeiffer Professor of Physiology Emeritus has influenced many students. He has been cited by many as a role model, an inspirational teacher, "a wonderfully enthusiastic purveyor of knowledge who made you think and see the joy in learning," as Cary Akins '70 once said in an interview.

Heart surgeon William H. Frist '78 (now a Republican senator from Tennessee) describes in his book *Transplant* (The Atlantic Monthly Press, 1989) how Barger's class was the highlight of second year. From the moment he first held a beating heart in his hand, Frist was hooked: "I could not put the heart down. I stared at it cradled in my hand, spellbound."

Though fully retired from research and teaching since 1987, Barger has nonetheless been so busy that at first he wasn't sure he'd have time to take on the Alumni Fund. He's been working on volume II of the biography of Walter B. Cannon with co-authors Saul Benison and Elin Wolfe. Volume I was published in 1987 by Harvard University Press-Belknap Press and the authors hope to complete work on the second half of Cannon's life within the next couple of years.

Taking on the chairmanship is Barger's way of "repaying the school for what it did for me." He was from a cattle farming family in western Massachusetts and left medical school with a debt of $3,500, which in 1943 was considerable. A strong motivation for him is to raise funds for more student financial aid through the Alumni Fund.

"Financial aid has always been a big problem for students," says Barger. "When I first started teaching, many students were just coming back from WWII and they were older and had families with many expenses." Barger pursuaded the medical school to start a "co-op" bookstore in the Vanderbilt basement to sell discounted books and instruments. It was so successful that the Coop opened a branch on Longwood Avenue. Barger also served on the financial aid and admissions committees in the mid-1950s, and was on the editorial board of the *Alumni Bulletin* for decades.

Since the 1960s Barger has also been involved with minority recruitment and retention efforts. In the 1960s he convinced the American Physiological Society to sponsor a program to encourage more minority students to pursue medicine and science. With classmate Paul Pfeiffer '43A and support from his family's Pfeiffer Foundation, he began a program at the medical school to fund research by HMS minority students, a program that continues today.

Though he had intended to become a general practitioner, Barger's mind turned to research during his internship at the Peter Bent Brigham and he never looked back. "Sam Levine '14 presented a case of congestive heart failure and I questioned his views of the pathogenesis. He said if you don't believe me, go over to the medical school, develop an animal model and study it." He took up the challenge, but one year of leave turned into forty-two.

During that time he and colleagues identified neural and hormonal changes that occur in heart failure as well as the kidney's role in the disease process. They also documented the role of networks of newly formed capillaries in the walls of coronary arteries near atherosclerotic plaques, which may play an important role in heart attacks. "My love has been to develop animal models of diseases and to translate the findings to clinical medicine."

In addition to his research laboratory, he ran a cardiovascular dog lab, which provided students with their first exposure to the physiological responses of living animals. He believed so strongly in how critical it was to teach students with animals that he spearheaded a campaign in the 1950s to pass the Pound Law so researchers could use pound animals that were destined to be destroyed.

As for his current quest, Barger would like to emphasize how important alumni annual unrestricted giving is to the school. As he points out, the medical school receives less than 4.5 percent of the endowment funds per year; with that calculation, it would take $30 million to generate the $1.3 million that was given to the Alumni Fund last year. "What alumni/ae give now is key to the success of HMS."

And in a program that was started last year, any unrestricted alumni funds generated beyond that $1.3 million will be added to the close to $600,000 traditionally allocated as part of the total $2.3 million annual scholarship budget. "I would like to raise enough to reduce student debt. I think

this is essential."

But above all, Barger would like to help improve communication between the school and its graduates. He wants to hear from alumni whether they have money to give or not. And such mail is for him one of the biggest thrills of this job.

Ellen Barlow

Hooked on Science

There are high school students in the Boston area who are not just taking notes as they study the brain; they are scrutinizing CT scans, doing penlight exams on each other, viewing film clips of seizures and keeping a patient chart as they piece together the puzzle of diagnosis. They are attempting to solve "Mary's Mystery," a problem-based case developed by physicians and neuroscientists at Harvard Medical School of a teenage girl brought into an emergency room with seizures? a drug problem? trauma?

If the future of biomedical science depends on igniting the interest of schoolchildren today, Joan Reede may hold one of the matches. As director of the HMS minority faculty development program, Reede has spent the past five years developing ways to inspire minority high school, college, medical school and graduate students to pursue biomedical science careers and to expose them to available funding opportunities. Part of her program's latest project is "Mary's Mystery," which has the ultimate goal of starting the pipeline back in middle school to instill the excitement of science.

"Children have to believe that science can be fun so they'll take to it later in college," points out Reede, who is also a pediatrician at Children's Hospital and a health policy researcher at Mass. General. "These are our future medical and graduate students."

Reede came up with the idea four years ago for the three-pronged initiative, which encompasses a teaching institute (formal training of teachers by HMS faculty, chaired by Martin Samuels, chief of neurology at Brigham and Women's Hospital), curriculum development, and Project Success, summer research at HMS for minority high school students, chaired by William Chin and Cliff Barger '43A. Gerald Fischbach, HMS chair of neurobiology, serves as the overall chair of the project.

Reede views this project as a way of bringing something HMS is known for—an exciting, case-based method of learning —to the community. After a great deal of curriculum development (with financial support from Harcourt General, Inc.), "Mary's Mystery" debuted in 1993 as an interactive live satellite program, 7 1/2 hours long, broken down into 5 sessions, and beamed to 70 schools in five states. Filmed in the Harvard hospitals, partly scripted, partly improvised, it was narrated by HMS neurobiologists David Potter and Ed Furshpan. Throughout the programs, the audience of teachers and high school students were given clues to Mary's problem and its possible treatment—through film clips of seizures, slides of neurons, radiographic images of the brain—and along the way learned some basic neuroscience, the process and rationale for the scientific method and differential diagnosis, and issues related to treatment planning. Public health concerns were also brought in: Mary's mother has insurance but not for Mary, so cost and benefits of possible recommendations must be considered.

"They can see that costs are an everyday problem, not just something debated in Washington," points out Reede. "They also come away better health care consumers. Doctors don't know everything; they collect information that takes them through the differential diagnosis."

Since high school classes are scheduled at different times, the next step was to modify the program (with funding from Harvard's Mahoney Neurosciences Institute) and put control in the hands of the teachers. Key to this are excited, well-trained teachers and plenty of hands-on materials: models of the brain, slides of neurons, penlights, and actual CT scans and medical records. Teachers were given a videotape featuring clips from the live program and newly developed video material, along with a teacher's guide outlining the educational objectives and additional classroom activities. This phase began in December 1994 in Cambridge, Brookline, Randolph and four Boston public high schools.

"Teachers are really partners in this," says Reede. "The teachers have been thrilled and we are of course thrilled that they are helping it work."

High school teachers will be able to take advantage of more formal training that will begin this summer at HMS, a one-week intensive program to introduce teachers to some of the neuroscience and clinical basics and to how to use the case method to present the whole package in an exciting way in the classroom. Dubbed the Howard Hughes Teacher Institute, it will be staffed by Harvard faculty, who are also involved in developing more curricula.

The Project Success arm of the initiative has been going on the past two summers: Boston and Cambridge minority high school students with an interest and proven ability in science are assigned to laboratories with specific lab-defined projects. They attend weekly lectures and go on site visits to hospitals and biotechnology firms. They are also matched with an HMS

minority medical or PhD student, who is a less intimidating few years older. As part of their research training, they learn how to do literature searches at Countway Library, write a research paper, and prepare an oral presentation (including slides and/or overheads) for HMS deans, faculty and their own families.

As a student from English High School who came to HMS last summer commented: "When people talk about our schools, it's always about drugs and violence and not the positive things we do. I never thought of myself as able to come into Harvard and now I feel part of it."

Fourteen students have participated in this program so far, another 10 are coming this summer, and everyone involved still feels a real commitment to them. "Students who have gone on to college write to update us on their progress, any difficulties they've encountered, or with questions on what classes to take," says Project Success coordinator Brenda Hoffman.

As Reede sums up her vision for these students: "Whether they become doctors, scientists or not, we just don't want their dreams to be limited."

Once the kinks are out of the high school curriculum, Reede says they plan to work on middle school and elementary school levels (although some middle school teachers have already adapted it). If all goes well, "Mary" may do for science what "Where in the World is Carmen SanDiego?" has done for geography.

Ellen Barlow

President's Report

by John D. Stoeckle

The Alumni Council's winter meeting covered old themes in today's times: appointments, a survey of students' HMS experiences, the teacher-clinician track, multiculturalism in student life, faculty composition and—money.

With teaching hospital-corporations developing larger "physician networks" (and more teaching in ambulatory practices), Dean Dan Federman '53 raised an old question: Who gets an HMS appointment and for what? Members thought appointments should be based on teaching commitment and performance, even though since the 1950s, HMS appointments have generally come to everyone with a hospital clinical staff appointment, whether they teach or not. Time and pay were other issues. Required teaching time by clinical faculty has been mandated at 5 percent (or two hours) of time per week, but has not been enforced or monitored. Teaching time has been volunteered as "duty" in exchange for the "privilege" of hospital admissions. No longer—with care, learning and incomes moving outside the hospital.

Regarding time, councilors felt department chairs should specify teaching time. But they were uncertain how to pay for or reward teaching, whose costs include the foregone fees of office visits, the salary from practice. Physician-teachers are unlikely to be funded directly for teaching, so group practices will need to establish equivalencies between teaching and practice. Most likely to be fiscal exchanges, the equivalencies for these opportunity costs of education should be incentives for teaching. Regardless, could the pay for educational work continue to be the rewards of teaching itself—the pedagogy, the teacher/student relation, those academic "perks" (the library, gym and CME courses), the appointment status, and even those new "teacher training" courses that enhance pedagogical performance?

A survey of 400 students (more than 50 percent response for all classes) was reported by Associate Dean Ed Hundert '84. Among their opinions and attitudes, the cost of HMS education was, not surprisingly, a major concern. Of diversity, they liked it in the student body, wanted more in the faculty, and appreciated the ombudsperson's office; of admissions, they liked the process and their class, but some felt the interview was not "user friendly" to all and that some disadvantaged whites were not represented; of the health services, they wanted more of what's at the HU campus at HMS (pharmacy and physical therapy) and more confidentiality in their clinic encounter; of the campus, they liked the Medical Education

Balancing Act

What it means in medicine to be married to your career has had different significances through the years. The spouses and significant others of alumni councillors joined students as the focus of discussion at the Thursday dinner prelude to January's council meeting. What emerged in the discussion, facilitated by Dan Federman '53, was that although juggling the professional and personal has always been a challenge (and in fact was cited as the greatest source of stress by alumni in the 1991 survey of physician satisfaction), home life is now not the only place where compromises are made.

Being married to your career now may in fact mean that you are married to someone else in

Center but not the Vanderbilt gym and were concerned about security in moving around at night; and, for their future, they wanted better career advising and clerkship scheduling, which now can be difficult with many leaving school and coming back at different times.

As chair of the teacher-clinician committee, Fred Lovejoy noted that 75 percent of medical schools now report having such a track, a third academic ladder on par with those for basic science and clinical investigation. As of 1994, 70 faculty had been promoted on this ladder, which is meant to be relatively small compared to the others. Approximately 4 percent of promotions in the last five years have been on this track, most in medicine and psychiatry. A fourth track, clinical scholar, is being developed, for those most active as full-time clinicians, while contributing to patient care with clinical studies, practice innovations and techniques, and teaching.

Multiculturalism was addressed, among students by Alvin Poissant, associate dean for student affairs, and in the faculty by William Silen, faculty dean for diversity. Dean Pouissant noted that the Office of Minority Recruitment and Multicultural Affairs is not limited to ethnic minorities but includes gays and lesbians. Students produce their own separate organizations, and yet work together on common projects—a directory of resources, newsletters and campus meetings, involving faculty when they can. To focus the curriculum on cultural issues in patient care, the first-year Patient/Doctor course, under JudyAnn Bigby '78 and Dan Goodenough, has begun a pilot section based at neighborhood health centers.

Only six weeks on the job, Dean Silen noted that he was just learning, surveying faculty and trainees to count the number and hear the needs of minority faculty in their career development at HMS.

Finally, David Bray, executive dean for administration, described the complicated financial structure of HMS amid the continued uncertainties in financing and pricing of its education. These costs don't seem to be going down at HMS or elsewhere, while the future salaries and jobs that medical education has promised certainly are.

John D. Stoeckle '47 is HMS professor of medicine emeritus and physician, Massachusetts General Hospital.

medicine. Most of the couples in the room were both professionals—many were both physicians—and concerns about family are not borne by one person over the other. Students clearly expressed that in addition to professional role models, they are anxious to hear how two-career couples keep their lives on track.

With a representative from each pentad of graduating classes, the Alumni Council is a microcosm of experiences through the decades from very senior alumni to the recently graduated. John Stanbury '39 was the only married person in his internship at Mass. General, marriage in the Oslerian tradition being taboo because a physician was to be totally dedicated to his profession. "John became involved in research so I was luckier than most women," commented his wife, Jean. "We had five children and John got home for dinner most nights."

On the other end of the spectrum was a medical student who came to HMS married; she found that there were about six other married students in her class. "Because I wanted to spend time with my husband, I decided that I would be a good student but I wasn't going to strive for the top." Although this provoked some consternation from one alumnus, he acknowledged the trap physicians are easily prey to, of thinking, "I'd be a good physician if only I gave one more hour away from my family."

Federman told the story of an alumna who was working at home on her computer when her 6-year-old came into the room and asked her what day it was. "Sunday," she said, to which her child responded, "Isn't that the day mothers and fathers are supposed to play with their kids?" She turned off her computer and they went to the zoo.

A gay medical student whose partner is a physician in New York commented that he wishes he had a mentor who could better understand his situation. He also introduced another element to the discussion: a friend's lover is dying of AIDS; what happens as a physician if your partner gets ill? As Suzanne Fletcher '66 said, "Realize that you are not locked in. You do what's important to you." Someone she knew took eight months off to spend time with her husband who was dying of leukemia.

Compromise seemed to be the operational word. "Whether you are in a heterosexual or homosexual relationship," said Fletcher, "the vast majority of physicians now are in relationships with other professionals. The bottom line is that there are only 24 hours in the day."

Traditionally, as Federman expressed it, "We train ourselves and our successors to be overly committed." Consensus appeared to be that institutions such as Harvard should help students deal with the practical dilemmas posed by a bottom line that, no matter how they juggle things, is not going to change.

Ellen Barlow

Alumni Week Program

Wednesday, June 7 to Sunday, June 11, 1995

Wednesday, June 7	**5-6:30pm**	**Coleus Society Wine Reception and Discussion**
	6:30-9:30pm	**New Paths of Leadership Open to Women in Medicine** **Dinner/discussion**
Thursday, June 8 **Symposium of the** **Class of 1970**	**9-10:30am**	**Women's Health** **Moderator: Elissa B. Arons** **Presentations by: S. Jean Emans** **William A. Bours, Joan Goldberg**
	10:45-12:15pm	**Basic Science Advances** **Moderator: Robert S. Munford III** **Presentations by: Michael M. Gottesman,** **Andrew H. Soll, David J. Wyler**
	2-4pm	**Personal Odysseys** **Moderator: John A. K. Davies** **Presentations by: George C. Fareed,** **Noel W. Solomons, James M. Herzog**
Thursday, June 8 **Faculty Symposium**	**9-12 noon**	**Moderator: Suzanne Fletcher '66** **Presentations by: Barbara Bierer '80,** **Paula A. Johnson '84, Elizabeth A. Mort '86,** **Eva Neer**
	12:15-2pm	**Estate Planning**
	2-4pm	**"Making of a Doctor" — NOVA series**
	2-3pm	**Meet the Authors: History and Historians of HMS** **Moderator: Clifford Barger '43A**
	3-4pm	**What Would You Like to Read in the** ***Harvard Medical Alumni Bulletin*?** **Moderator: Arthur R. Kravitz '54**
	3-4pm	**Meet the Associate Dean for Admissions** **Gerald S. Foster '51**
	4pm	**Tour of Vanderbilt Hall and the Medical Education** **Center by HMS students**
Friday, June 9 **Alumni Day**	**9-9:30am**	**Annual meeting**
	9:30am	**Alumni Day Symposium: NOT OF AESCULAPIUS BORN** **Moderator: Daniel D. Federman '53** **"Back Then"—Dora Benedict Goldstein '49** **"Are Women Different?"—Gerald S. Foster '51** **"Professional Paths, Private Lives"—** **Stephanie Pincus '68** **"Are We Still on Trial?"—Donnella Green '98**
	12 noon	**Harvard Medical School: 1995** **Daniel C. Tosteson '48**
	12:30pm	**Reunion Class photographs and lunch** **on the Quadrangle**

Dora Benedict Goldstein '49 remembers few difficulties as a member of the first class to admit women to Harvard Medical School: "My own classmates—the men and the women—were in coed schools before they ever got to HMS, so they didn't feel that anything was that different here. The faculty did notice us, and often commented, 'This is the first time I've ever addressed the class as Ladies and Gentlemen'."

It took several changes—most of them societal—for Goldstein to realize the impacts of being one of the first women to enter medicine at large, let alone at Harvard. While she doesn't regret the choices she made, such as putting her husband's career first and taking several years off to raise four children, she now realizes that they were largely dictated by the society of the 1950s and early '60s. "We were so driven by circumstance back then," she observes. "I don't think we were nearly as directed and farseeing as women are now."

"Circumstances" had much to do with Goldstein's own partially-delayed career. During her second year at HMS she met her future husband, Avram Goldstein, who was an assistant professor in the Department of Pharmacology. They married in 1947 and by her senior year at HMS she was pregnant with their first child. When her husband was invited on a fellowship to the University of Edinburgh, she followed him there, where their first child was born. Some time later, when she was working on her post-doc in microbiology at Harvard Medical School, she abandoned this first specialty to take up that of her husband; her husband had gotten a full professorship at Stanford University School of Medicine and appointed Goldstein as his research associate in pharmacology. "Back then," she comments, "we didn't realize how inappropriate that arrangement was."

It wasn't until the 1970s that Goldstein realized that she had the option to be far more ambitious about her medical career. "One day a good friend of mine walked in my office and said, 'What are you doing in this job?' It was a real eye-opener. She recognized that I had the same degree as my husband and the same training."

After her husband had retired as chairman of the Department of Pharmacology at Stanford, Goldstein became a full, tenured professor in her own right. She was 56 years old. "We had to wait," she explains, "otherwise it would have been seen as nepotism." Meanwhile, her husband fully supported her professional advances. "His eyes began to open about the same time mine did." Goldstein says that her promotion was part of the movement at Stanford and similar schools to improve the status of women.

Looking back, she comments, "I can't believe how naive we were." Long before her full professorship was announced, Goldstein had become well known for her expertise as a researcher of alcoholism and its effects on brain chemistry. She retired in 1992 when retirement at age 70 was still a legal requirement. Since then she has remained active in helping Stanford develop programs that will improve the status of women and minority faculty at the school. She is currently co-director of the newly created faculty mentoring program at Stanford. As the mother of a son, Michael, who is gay, she is also very active in a national support group called Parents, Families and Friends of Lesbians and Gays. "I'm a very busy person," she said.

Sarah Jane Nelson

Operating Room, Women's Hospital, Philadelphia, PA. circa 1903

How Women Made History in Medicine

by Regina Markell Morantz-Sanchez

Remember a riddle that made the rounds in academic circles in the 1960s and 1970s. It began with a terrible automobile accident involving a father and his young son. The father died instantly, while the son, in critical condition, was rushed to the hospital in a furious attempt to save his life. Just before the intricate neurosurgery was to commence, the surgeon glanced at the patient and suddenly cried out: "My god! I can't operate on this patient, he is my son!"

"How could this be?" the riddler asked, and for 10 minutes or more, groups of perfectly intelligent individuals proposed the hokiest and most unbelievably complicated theories to explain how this particular surgeon could be confronting his son when the father had just been killed in a car crash. This riddle always stumped its audience. Indeed, never do I remember hearing someone answer with what today I suspect would be the obvious: the neurosurgeon was a woman!

The changes in the medical profession in the last two decades have deprived this riddle of its power to mystify an audience, and such changes are worth marking and celebrating. But as we do so, it seems appropriate to remember the past, because it has much to tell us about the present.

Photos courtesy of Archives and Special Collections on Women in Medicine, Medical College of Pennsylvania.

Women in the medical profession have a rather formidable historical legacy, one which is roughly 150 years old.

One could, of course, spend a good deal of time speaking of the obstacles early women doctors overcame in the face of persistent discrimination. Many of you know, of course, that Harvard University, in keeping with its determination to stand always above the rest, bested most other medical institutions even in its resistance to women. Harvard remained one of the last holdouts against them, admitting women to the medical school only in 1945, mostly as a response to the manpower shortages of the world war.

Along the way there were several earlier attempts to open up discussion of the issue, not only by women but also by a handful of brave and sympathetic male faculty. Qualified female students knocked at Harvard's doors in the 1850s, the 1860s, the 1870s, and several times again in the early decades of the twentieth century. Always they were rebuffed, because the time did not seem "expedient." The institution was willing to tolerate a few scattered women scientists as "invisible faculty," to borrow a term from Dean Eleanor Shore '55, the most distinguished of which was Alice Hamilton, a physician with an already distinguished career. As soon as she agreed not to expect her quota of football tickets, Hamilton was appointed assistant professor of industrial medicine in 1919. But a few women PhDs notwithstanding, admitting female students was another matter entirely.

Much of the lore around the rejection of women can be wickedly amusing to contemporary listeners, especially when such stories expose the silly and contradictory notions about women's physiology and intellectual abilities that prevailed a century ago. But there is more to the history of women physicians than mere stories of discrimination. In spite of their difficulties, women doctors did carve out a place for themselves in the nineteenth century. Though it was a highly contested place, it is to that narrative that I wish to turn now, because it still speaks to us today.

Women entered the medical profession by championing an extremely powerful paradigm of ideal womanhood that became so embedded in nineteenth-century American culture that one easily finds traces of it in discourse about gender today. Though women physicians did not invent this ideology, they believed in it, helped to define it, and used it to achieve their own ends. It was an ideology colored by the emergence, since the seventeenth century, of a scientific discourse that emphasized sharp and incommensurable differences between the sexes, differences that theorists increasingly viewed as rooted in biology. According to its dictates, women's mission in society was motherhood.

Though the Victorian sanctification of motherhood could and cer-

tainly did sequester most women in the family at home, it could also serve as a persuasive justification for a more integral role for women in society at large. For it was as mothers in their role as moral arbiters that groups of white middle-class women and, especially after the Civil War, black women as well, participated in campaigns for social reform and developed programs that eventually laid the groundwork for institutions now associated with the welfare state. Women doctors and the movement to train women in medicine grew out of these larger reform efforts.

Indeed, women did not always have to be mothers in the physiological sense. Elizabeth Blackwell, with whom you are all familiar as an early leader in the movement to train women in medicine, could speak repeatedly of "the spiritual power of maternity," which all true physicians—male or female—must possess. By this term she meant something very akin to Erik Erikson's idea of generativity, which he defined as the task of establishing and guiding the next generation. Like Erikson, Blackwell interpreted "the spiritual power of maternity" in the broadest possible terms. Not only physicians, but all mankind must learn the lessons it had to teach, whether individuals actually had children or not.

Well into the twentieth century, women physicians were reiterating similar themes. "Being women as well as physicians," acknowledged Margaret Vaupel Clark, president of the Iowa State Society of Medical Women in 1908, "we share with our sex in the actual and potential motherhood of the race. Being women we make common cause with all women....and being women and mothers, our first and closest and dearest interest is the child."

In order to understand the impact of such an ideology as it was used by women physicians, it might be helpful to note that before the bacteriological revolution at the end of the nineteenth century, the body was viewed holistically, as an organism in delicate relationship to its environment. Disease resulted when something occurred to upset that equilibrium. The dictates of such a system demanded that the physician know his or her patient well. The "art" of medicine lay with the doctor's ability to balance the patient's history and unique physical identity against the family's constitutional idiosyncrasies and relevant environmental, climatic and developmental conditions.

Given the qualities needed in good practitioners, women have a natural vocation for it.

This therapeutic framework included the assumption that intuitive factors were essential to successful diagnosis and treatment. "The model of the body, and of health and disease," the medical historian Charles Rosenberg has written, "was all-inclusive, anti-reductionist, capable of incorporating every aspect of man's life in explaining his physical condition." Just as man's body interacted with his environment, so did his mind with his body, his morals with his health. "The realm of causation in medicine was not distinguishable from the realm of meaning in society generally."

Female medical leaders fashioned a formidable argument for training women in medicine by wedding the Victorian cultural paradigm about women and motherhood to traditional assumptions about the role of the physician. If the doctor's responsibilities were integrally linked to the family—still the central locus of medical caregiving in this period—who better than scientifically trained women could monitor family health?

"Ladies," the dean of the Woman's Medical College of Pennsylvania told a graduating class in 1858, "it is for the very purpose of making home enjoyments more complete that you have been delegated today to bear health and hope to the abodes you enter."

Elaborating on such sentiments, Elizabeth Blackwell observed, "Our medical profession had not yet fully realized the special and weighty responsibility which rests upon it to watch over the cradle of the race; to see to it that human beings are well born, well nourished, and well educated." Such work, she believed, was "especially encumbent upon women physicians," who better understood "the all important character of parentage in its influence upon. . . the race."

Moreover, given the qualities needed in good practitioners, women had a natural vocation for it. They were, argued Marie Zakrzewska, physician and founder of the New England Hospital for Women and Children in Boston, "by nature sympathetic and more caretaking in sickness."

"The true physician," wrote Angenette Hunt in her graduating thesis from the Woman's Medical College of Pennsylvania in 1851, needed "gentleness, patience, quick perceptions, natural instinct which is often surer than science, deep sympathy." All these qualities, Hunt believed, "belong to the sex in an eminent degree."

There were two distinguishing features of female medical professionalism in the late nineteenth and early twentieth centuries that arose from these cultural assumptions. The first was an emphasis on prevention. The second was the attempt to teach students that the doctor-patient relationship was absolutely central to diagnosis and treatment, while technological interventions, though important, were to be used selectively and secondarily. Most women physicians remained wedded to a belief in the psychosocial components of illness, in spite of

increasing pressures by the end of the century to discount such an approach. I am not arguing that as a group they were more reluctant to accept scientific medicine than men, merely that their standpoint and self-perception led them to slightly different perspectives on medical care.

The theme of preventive medicine emerges as a recurring refrain. Marie Zakrzewska, for example, justified her use of placebos in special cases as a way of teaching people how to keep well. Others gave lectures on physiology and health to the public. The early women's medical schools and hospitals built such concerns into their curricula. The Medical School of the New York Infirmary for Women and Children boasted proudly of the first course in preventive medicine offered anywhere in the country. A year before the founding of the school, the hospital had established the office of "sanitary visitor," an individual designated by the hospital to give special attention to the physician's role in patient education. The position was usually filled by a young medical graduate wishing to gain further clinical experience. The work entailed going into the homes of the poor, checking ventilation, cleanliness, diet and general hygiene, and giving families advice on how to keep themselves healthy. Other women's institutions around the country followed suit in cities like Cleveland, Chicago and San Francisco.

The teaching and practice of obstetrics was another area that reflected women physicians' strong concern with both prevention and the psychosocial parameters of disease. In the last third of the nineteenth century, this specialty lagged pitifully behind others. Most institutions remained content to teach midwifery solely through didactic lectures.

In contrast, Anna Broomall organized an outpatient department at the Woman's Hospital of the Woman's Medical College of Pennsylvania in 1876, which eventually offered the first prenatal care in the country. Each medical student was responsible for the independent management of at least six obstetric cases before qualifying for the degree. The New York Infirmary provided a similar experience in obstetrics and gynecology. The 1888 faculty minutes refer to a requirement that every student attend at least 12 cases before graduation.

A comparison of male and female therapeutics at two Boston obstetrical hospitals during this same period revealed that, although differences in the mechanics of obstetrical practice were minimal, subtle but meaningful variations in physician/patient interaction may have made the experience of being treated by a woman physician a

Well Baby Clinic, Barton Dispensary, Philadelphia, PA, circa 1900

Lecturing medical students at Women's Medical College of Pennsylvania (WMCP). circa 1898

more positive one for the patient. For example, women doctors made rounds more often than the men, and prescribed mild, supportive therapies, while their male counterparts did not. The women concerned themselves with their patients' social situations: many an unmarried mother was settled in a job after she left the hospital, and countless poor patients were kept long after their recovery until proper housing could be found for them.

About this work a young woman intern in the 1870s wrote to a friend, "Most of the women are unmarried, and, except for the respectability of the thing, by far the greater number had better not be—the husbands being brutal wretches who abuse them in every way." Proud of the efforts of the hospital's "lady managers" to help such unfortunate women find work and a home, she concluded, "I have always been interested in such work...and I am very glad, as you may imagine, to take any part in it." Even today, studies reveal that women physicians often spend more time with their patients and usually take a more thorough history.

With the bacteriological revolution at the end of the nineteenth century, all physicians increasingly confronted a tension between "art" and "science" in medicine, but women doctors felt that tension most acutely. They had entered the profession believing in women's special abilities to alleviate pain and suffering. They had wrestled with their dual identities as women and as doctors. They had emphasized the importance of prevention over cure, and the duty of doctors to bring about social reform.

Yet, until bacteriology injected a specific kind of science into medical practice—one characterized by an approach to knowledge that was allegedly dispassionate, precise and subject to suitable tests of proof, evidence and the collective criticisms of the scientific community—they functioned in an atmosphere colored by an older concept of professionalism. Accepted by both sexes, this professionalism had maintained a place for subjective forms of knowing and stressed the therapeutic powers of moral and social concerns.

To someone like Elizabeth Blackwell, who believed powerfully in medicine's responsibility to reform society and specifically in women doctors' obligations, bacteriology threatened to destroy this world, undermining in the process their raison d'être. Indeed, Blackwell's ideas on medical education and practice represent a particularly interesting and per-

sistent strain in the thinking of women doctors, one that was, as we shall see, remarkably prescient in understanding the direction medicine was moving.

Rankled by the exaggerated claims of the early microbe hunters, she devoted considerable attention in her later writings to the dangers of medical materialism and questions of what the pursuit of "science" really entailed. In her view, bacteriology could never fit her definition of "true science," because its theory of disease causation was overly simplistic. Bacteriologists consistently overlooked the connection between the mind and the body.

"We can take a steam-engine or a watch to pieces, examine their parts, repair them, and put them together again," she wrote in 1898. "but a living thing cannot be treated in the same way." To regard human beings as simply "material bodies," without considering the effect of the mental state on the health of those bodies was bad science and consequently bad medicine. "Sanitary law," she argued, "teaches us that disease is produced by many causes, not solely by a specific microbe."

Moreover, laboratory research too often entailed research without patients. Detachment and objectification inevitably ensued; medical students became inured to "intelligent" sympathy with suffering, which, she believed, was the hallmark of a good physician. Soon, she predicted, they would be regarding the sick poor as "clinical material." For Blackwell, such an approach to medicine was almost a contradiction in terms.

While experimental investigators rightly viewed themselves as progressives whose discoveries would rapidly advance the treatment of disease, she sided with her more traditional colleagues who still venerated a personal, humane style of interaction oriented toward the individual patient. She deplored the new image of the medical scientist that emerged at the end of the nineteenth century and these concerns blinded her to real technical and scientific advances. Calculating, manipulative and objectively detached from the object of study, this model of the physician seemed a wholesale rejection of the interpersonal dimension of medicine, on which her entire conception of the physician's task rested.

Coeducation promised more to women than it delivered.

The anxieties that plagued Blackwell also troubled other female medical educators, who continually stressed the importance in therapeutics of the "art" of medical practice, eschewing biological reductionism. Sarah Adamson Dolley urged her students to meet patients "as something more than a static entity or dynamic quantity whose muscles, nerves and joints are not simply a bundle of levers, pulleys and hinges, but are the instruments of that mysterious something which we call life."

Mary E. Bates was particularly disgusted in the 1890s by a seminar on gynecological surgery sponsored by her state medical society. The speakers, she complained, "limited their attacks to the offending...uterus, while practically ignoring the patient." Similarly, Dean Clara Marshall of the Woman's Medical College of Pennsylvania emphasized this point to her graduating classes in Philadelphia. Study people as well as diseases, she warned. "A distinguished physician has said 'There are no diseases, only patients'," she told a group of students in 1879. "And you will often reach patients and cure them too, by a scientific use of your humanity."

Susan Dimock, the brilliant young surgeon at the New England Hospital, frequently commented that if she were asked "to do without sympathy or medicine, I should say do without medicine." Over 65 years later in 1937 the surgeon Rosalie Slaughter Morton agreed. "A woman physician sees life without its mask," she observed. "[She] gets closer to the inner thought of other women in understanding the many domestic and social factors in illness...because her mother heart has scientific facts to support intuition and sympathy."

The female faculty at the women's medical schools in the nineteenth century understood that the best way to produce humane practitioners was to create a humane and supportive atmosphere for their students. But, in spite of these achievements, separate women's institutions was never the goal of the women's medical movement, but only a stopgap measure until the men's institutions would admit female students. A year before Johns Hopkins opened in 1892, for example, Mary Putnam Jacobi wrote, "There is no manner of doubt that coeducation in medicine is essential to the real and permanent success of women in medicine. Isolated groups of women cannot maintain the same intellectual standards as are established and maintained by men."

Whether Jacobi was indeed right in her assessment is a complicated question. Let me say only that when state universities like the University of Michigan, and then a premier school like Johns Hopkins opened their doors to women, female medical educators took such developments as evidence of a long-awaited breakthrough and their optimism knew no bounds. Most believed the barriers to women's progress would fall by the wayside one by one, and women would, indeed, have access to the medical profession, to borrow from the wording of the Johns Hopkins charter, on the "same" terms as men.

But coeducation promised more to women than it delivered, and there were myriad reasons for this. One significant one was that medical professionalization itself, which was driving

the reorganization and improvement of medical education at the end of the nineteenth century, was essentially a profoundly "gendered" phenomenon. What I mean by this is that the new medical schools, residency programs, specialty societies and teaching methods were structured entirely in response to the male life cycle. Professions, after all, were structured as two-person careers, with men performing respectable service in the public sphere, while at home their wives raised their children and managed their households. And, after the bacteriological revolution, when a new kind of science injected itself more and more into medical care, it too took on characteristics that were increasingly defined as "masculine."

One need only look as far as the conclusion of Sinclair Lewis's novel *Arrowsmith* to understand the ways in which the pure scientist was scripted in concepts of masculinity. For Lewis, whose technical advisor in the writing of this novel was the scientist and writer Paul de Kruif, Martin Arrowsmith represented the new medical hero, full of integrity, but inevitably alone, doomed to withdraw even from wife and child in order to pursue his vision. Of course the gendered nature of these new structures was well hidden—neither understood nor acknowledged overtly until over a half-century later. Thus, when women involved themselves in the study of medical science, they mistakenly believed that they were entering "neutral" or —to use an even more loaded term—"objective and impartial" territory. Because of the meritocratic language used to describe achievement and success within these structures, they barely noticed or understood the extent to which their position could be eroded by subtle forms of discrimination.

Looking over past issues of the *Harvard Medical Alumni Bulletin*, I was struck by examples of this culturally induced myopia among the first group of women graduates of the medical school. It is not surprising, given the fact that Harvard was a "hold out" against women for so long, that the female students who were eventually admitted in those early years had to be overly qualified and aggresively determined. They also fared best facing obstacles with a particular vision of the world, one that helped them brush off or accept without analysis the myriad ways in which they were treated differently.

Doris Bennett '49 was an especially cheerful example of a plucky woman with marvelous coping strategies. A little over a decade after her graduation, she recounted her medical school years for a special issue of the *Bulletin*. It was a story full of humor, much of it based on poking fun at the difficulties the women encountered when confronted with faculty and patients who didn't quite approve of them. In this breezy account, there are no serious revelations of private anguish; the narrative is a linear one of increasing self-confidence and gradual acceptance by male colleagues.

And yet, in 1975, when the *Bulletin* once again examined the experience of women at Harvard, Bennett was not so sanguine. The women's movement had opened her eyes to situations previously gone unnoticed, because 25 years earlier she had accepted without question the construction and deployment of an elaborate set of specific images about women's role, which told her what "natural" behavior was for women in American society. An older and wiser Doris Bennett, looking back on what she had written in 1961, offered the following update.

Fifteen years ago, I wrote a lighthearted article about the hectic but happy life I was leading trying to combine medicine, marriage and motherhood. Now, as I look back upon my endeavors, I think I was not only lighthearted—I must have been lightheaded as well. Only a chronic case of Levitus cerebri, *the result of 30 years of intense brainwashing, could have made a person behave as I did then. In 1961 I was the brainwashed product of my culture's view of woman's place in society. Since I had chosen to enter a profession primarily reserved for men, my 30 previous years of cultural indoctrination caused me to feel that I therefore had to prove my femininity—I had to show that I was a woman. In the 1950 to 1960s my consciousness had not yet been raised. It never occurred to me that as a woman I deserved some liberation from the age-old mores, which decreed that it was primarily my responsibility to maintain the home and raise the children. I went all-out to be the good wife and mother that I believed nature had meant me to be.*

Bennett was an extraordinary woman, full of the personal strengths that helped her orchestrate a productive life as a full-time professional, as well as a wife and mother. But I have no doubt whatsoever that she experienced the full range of difficulties at Harvard encountered by other women physicians at coeducational medical institutions. For example, disapproval—sometimes vicious— from male faculty was standard, and so were unacknowledged female inhibitions that could create unexpected embarrassment in the classroom. Pressure to find the right posture in relationships with male students was another dilemma noted over and over again by women physicians in their memoirs.

More serious and more confusing were the emotional conflicts generated by the enormously high performance expectations in personal and professional life that individuals internalized and peers, teachers and the institutions reinforced. And, of course, there were virtually no female role models available to offer support or advice. As Carol Nadelson and Malkah Notman noted in 1974.

Women often accept the "peculiarity" of their position as doctors, and they may share the prejudices of men regarding their capabilities and the legitimacy of their career aspirations. The woman who chooses to pursue "two lives" in our culture

may have to face conflicts that she is unprepared to cope with....The development of a woman's self-esteem and self-image cannot be measurably improved by the imposition of these additional burdens of confusions and guilt. If we define success in terms of carrying through of one's goals, then we must also look at the high price the successful woman must pay in our culture.

One could argue that as the numbers of women in the profession approach 50 percent, many of these difficulties will eventually solve themselves. But there are another set of problems— a legacy from the nineteenth century—which I doubt are as easily set aside. These are questions that are very much contested in conversations about medical professionalism today. Because most young girls are still socialized to function primarily in the privacy of the family, where sentiment, intuition, feeling and interrelatedness still predominate (and, I hasten to add, our culture values these attributes highly if they remain located in "family values" discourse), women who choose medicine experience uneasiness with its alternative set of values, which are presented as rational, scientific and gender neutral, but in reality are not only class-bound, but are also stereotypically "masculine."

I am talking here about a set of binary opposites that have structured images of professionalism for most of the century: male/female, objective/subjective, culture/nature, rational/emotional, active/passive, public/private, science/ intuition. And it is in their discomfort with this professional discourse that contemporary women physicians connect, probably without even knowing it, to the legacy of their nineteenth century predecessors.

Although they held to a different theory of sex differences, early women physicians were instinctive critics of the dehumanization inherent in industrialization. They feared the tendency of the new capitalist order to turn people into commodities, even as they hailed the positive role of individualism in bringing about female emancipation. From their vantage point as women they quickly comprehended that the rationalization of human knowledge could be carried too far. They brought to medicine a critique of the growing primacy of cure over care. Though their values were ultimately swallowed up in the triumph of twentieth-century medical professionalism and the ascendancy of a particular definition of science, this perception formed the basis of their criticism of the profession to which they so fervently wished to belong.

Contemporary women physicians have continued to find fault with the

Histological and Pathological Laboratory, WMCP. circa 1896

Physician from the Women's Medical College of Pennsylvania Hospital making a house call at a South Philadelphia tenement. circa 1916

masculine professional style. It is almost 15 years now since Carola Eisenberg, then dean of student affairs at Harvard Medical School, urged at a conference on women's role in medicine that "strength is not incompatible with compassion." She was seconded by Carlotta Rinke, who observed, "If what is epitomized as 'a good physician' embodies a masculine set of traits and ideals, women will invariably suffer an identity crisis in attempting to adapt their womanhood into a male professional model."

Of course gender prescription has become more flexible, even in the short time span of the last decade. But shifting paradigms have not totally transformed the reality of women's lives, and I was reminded of that vividly when, only a couple of weeks ago, I spoke to a group of young women psychiatry residents and attendings, whose struggles and dilemmas—about time management, balance between work and family, and professional advancement—fell neatly into all-too-familiar historical categories.

Moreover, professional values have responded only marginally and selectively to female perspectives. Women are seen and still too often see themselves as potential disrupters of the routines of professional life. In truth, women physicians, like other women professionals, will continue to pay a high price for their professional and personal choices until the ethos and structure of medical education and practice can be altered to accommodate their needs and values in a more fundamental way.

What is new and exciting about this historical moment is that women are finally becoming a critical mass within the profession. This fact should allow them to give strong and emphatic voice to a widening range of new and critical professional concerns. I rejoice in that fact and celebrate with you this moment, hoping that the legacy of the past can enrich solutions to present dilemmas and point in some small way toward a better future for us all.

Regina Markell Morantz-Sanchez, PhD is professor of history at the University of Michigan. She is the author of Sympathy and Science: Women Physicians in American Medicine *and* In Their Own Lives: Oral Histories of Women Physicians.

"It is time to send another Jefferson to Washington" is the campaign motto of **Mildred F. Jefferson '51,** who in the past 13 years in Massachusetts has made two bids for the Republican party's nomination for U.S. senator. Though so far unsuccessful, Jefferson is not a woman who is likely to give up.

Through sheer determination, despite roadblocks along the way, Jefferson was the first woman surgeon to come out of Harvard Medical School. "I enjoyed medical school very much and only developed problems when I chose my area of specialization," says Jefferson. "Surgery was not the usual track and women who had considered surgery had been talked out of it."

Jefferson was also the first Negro woman to graduate from HMS. (Negro is the term she prefers, explaining that as Earnest A. Hooton wrote in a 1925 book *Young Man, You Are Normal,* race is useful only as a physical description. "I am not African-American, a hyphenated American; I had many ancestors who did not come from Africa.") Race was not an issue for her during training; she saw the medical community as close knit and friendly, despite what one might expect in the Jim Crow years. As she points out, it was after the '60s and '70s, and the divisive conflict over school busing, that the "unpleasantries" in Boston began.

Although she grew up in a segregated, small town in Texas, called Carthage, she was 8 or 9 before she even realized the town was segregated. It was nothing she took seriously, particularly since intellect was prized by the townspeople and the school superintendent. When she and another student from the segregated school scored highest in the school district on IQ tests, they were brought to an assembly at the "other" school and applauded for their achievement.

The only child of a schoolteacher mother and Methodist minister father, Jefferson and her education were the priority. Her parents bought her any book she wanted, and she and her mother would walk eight miles to read her uncle's daily newspaper. Considered gifted, she was accelerated through school and graduated from Texas College at age 18.

The idea of being a doctor "crystallized at an early age," says Jefferson. There was a family physician in a nearby little town who let her follow him around. She was only about 5, but remembers being impressed that people always got well. "I told him I wanted to be a doctor and he said, 'You go right on ahead'."

She had fallen in love with Boston because of the literary circles of Beacon Hill and the works of Emerson and Amy Lowell. "I expected to become an educated woman and felt that Boston was where I should be." So when she came to Tufts to get her master's in science, she felt right at home. "I didn't know there were odds against what I was doing," she says. "I made a list of three medical schools and applied." At age 20, she was admitted to HMS, one of six women in her class.

She trained in surgery at Boston City Hospital up until her last year when, she says, a new chief appointed to her service came in with the attitude that "surgical training is too precious to waste on a woman" and took her off the training ladder. She did various fellowships at Boston hospitals for 10 years before "Boston University developed an affiliated program with Brockton, Carney and Malden hospitals, which enabled me to walk in as a chief resident."

Although she is still an assistant clinical professor of surgery at Boston University School of Medicine, since 1982 she has devoted more and more time to public policy issues. She has been active in the Massachusetts Medical Society, formerly as a councillor from Suffolk District and now as a member of the House of Delegates, "attempting to encourage fellow physicians to take an active role in the government's decision-making process on health care reform."

Her consuming concern since 1970 has been what she considers "the cataclysmic social policy" of the country regarding abortion. As someone raised with the Judeo-Christian ethic of the sanctity of life, and as a physician who she says "is guided first by the ethical constraint to do no harm and by the tradition that separates killing from curing," she is appalled by a social policy that she says asks a doctor to kill. She is a founding member of the Massachusetts Citizens for Life and the National Right to Life Committee. "I don't do things half way; I get involved or I leave them alone."

Her right-to-life stance is part of her campaign platform and the focus of much of her energy. She speaks around the country and has been interviewed for newspapers, magazines and on television shows from "Good Morning America," "Nightline" and "The MacNeil-Lehrer News Hour" to local shows such as "Consider This." She has received 28 honorary degrees and has been listed as one of "Ten Most Admired Conservative Women" by *Conservative Digest.*

In addition to local political activism, Jefferson campaigned for Ronald Reagan in 1980 and 1984, and for George Bush in 1988 and 1992. She was a Bush delegate to the 1992 GOP National Convention. For her, politics is just another phase of what she believes she has to accomplish in medicine. And asked when she plans to retire, she responds with conviction, "I will never retire."

Ellen Barlow

The Fifty-Year Difference

What the Men Think

by Warren Bennett and Ernest Darkoh-Ampem

Warren Bennett '47 was a third-year student at Harvard Medical School when 12 women were admitted. Ernest Darkoh-Ampem '98 is in the first class where women are the majority. Having heard from many of the women, we invited these two men to talk to associate editor Terri L. Rutter, and to each other, about their perspective on the women amongst them.

HMAB: *What was it like when the ladies arrived?*

WARREN BENNETT: Well it was very interesting. I think a large segment of my class had feelings one way or the other but kept them to themselves. There were a few who thought it was a good idea and of course very quickly I became one of those. But one of the medical school fraternities, Sigma Nu, decided it was their mission to make life as uncomfortable as possible for women and some of them were quite nasty. There were little snubs and they were often rude in the common room.

photo by Beth Beighlie

They decided they were going to run a dance in honor of the women and invited everybody. There was one woman in the class who fancied herself a chanteuse. So the Nu Sig boys invited her up to sing, and while she was singing, someone casually handed her a glass of beer or something, which they had laced with chloral hydrate. She passed out on the stage and had to be carried out.

HMAB: *Ernest, what is it like for you to hear stories like this? That must sound pretty foreign compared to what your class is experiencing, or do you have your own stories to share?*

ERNEST DARKOH-AMPEM: Initially I was really surprised after arriving to find out that it was only 1945 when women were first admitted. I thought that was shocking. In terms of the attitude in my class, it would be highly unlikely to have anything like that, but then sometimes I wonder if it's just because the rules are different.

HMAB: *Were there advantages for you when the first class of women came?*

WB: I think so. It added diversity to the student body and I think it changed attitudes, ultimately. I remember I came down one Sunday evening into the dining room where there were usually a lot of people scattered around eating. That evening it was empty except over in one corner there were a large number of students gathered. I wormed my way through the crowd to see what was going on and there in the middle was this young lady holding court. That's how I first met my wife, Doris Rubin.

HMAB: *Wasn't there a stereotype when women first came that they were here to marry a doctor?*

WB: Well there were some who said that. There were some who said the women were not going to be really serious about it, that they would all drift away. But they were wrong, because the women did extremely well and with the exception of the one that left, they all finished and they all had good internships and good careers.

My wife, who graduated cum laude, ended up with a rotating internship at Faulkner Hospital, which was all right but it's not MGH. Each time she interviewed at a Boston teaching hospital she would get some excuse. For example, Beth Israel told her she was a strong candidate, but they had problems with facilities for sleeping in and didn't have locker space for women and various thin excuses like that. It was really quite irritating. She felt strongly that she wanted to stay in Boston because I was in residency in Boston at the time. So finally she took a rotating internship at the Faulkner.

One time she had a Mass. General rotator for three months who was a

junior resident in medicine. He had an adjacent on-call room to hers and they were both on call one evening when he paged her. He asked if she would do something for him and when she said sure, he said "I left a white coat of mine on my bed in my room upstairs that needs a button sewed on."

HMAB: *Ernest, have women in your class shared with you stories of harassment, maybe not something as blatant as that, but do you get a sense that women are treated differently?*

ED-A: It's been a lot more subtle. There have been a few instances where women in tutorials have expressed that they feel sort of shut out; there'll be a discussion going on at the table and they will be left out. I know another main complaint is that in the curriculum, the male body is the standard. A lot of things are said assuming that, oh well, it would be the same for women.

WB: What about the proportion of women on the faculty?

ED-A: It's quite low.

WB: The numbers were nonexistent when I was here. There were a few very famous women, seniors at the Mass. General like Marian Ropes, a rheumatologist, but for the most part they were very scarce.

HMAB: *How do your male classmates react to the dearth of female faculty? Do they notice or comment?*

ED-A: To be absolutely honest, maybe somewhere inside most of my male classmates may wish there were more female faculty but I don't think they are really preoccupied with the issue that much.

WB: My suspicion is that students don't feel that strongly whether the faculty is male or female as long as the faculty is high quality.

ED-A: The one thing I notice is that when we do have women faculty, sometimes I get the sense that the class is a bit harder on them. We've had male faculty who stood up there and absolutely have been really bad, but they somehow don't get as much flack.

HMAB: *What effect do you think women are having on medicine? Some have said that women talk more with patients, that they spend more time getting in touch with their patients' psychology. Do you think this is true?*

WB: I think it's hard to generalize. You'll find men who are equally that way in medicine and some who are not. People who have what medical people like to call the surgical personality are less likely to be communicative or to be good listeners, but I think that one of the potential strengths of women in medicine is that they are very good listeners.

ED-A: Among my classmates in general, and this a totally subjective opinion, I feel that women are more comfortable being in touch with issues that a lot of men can be a little uncomfortable about.

HMAB: *Ernest, you are one of only two men in the American Medical Women's Association, which would never have even occurred to someone in Dr. Bennett's class.*

WB: No, I think that maybe we would have been drummed out.

ED-A: One thing that I've never been interested in is being in an ineffectual organization. AMWA seemed to have good solid direction. It seemed very committed and the issues they dealt with addressed basic inadaquacies. I just liked their passion.

HMAB: *Socially between men and women it must have been very different in 1945. Today, is there still the belief that women might be here to marry a doctor?*

ED-A: It's totally gone.

WB: I think in the days when my wife and I were students, men were subject to a certain amount of disapproval from classmates if we fraternized with the women at school. You had to be a little gutsy to do it. Everyone was friendly and so forth, and believe me there were a lot of my classmates who went out with and even married women in the class, but generally you had to stick your neck out to go out with the women.

photo by Beth Beighlie

HMAB: *Do you have anything you'd like to ask each other.*

ED-A: *Your attitude seems very different than your classmates. To what would you attribute to your different perspective?*

WB: My perspective was my association with my wife and her colleagues. That had a great deal to do with shaping a different attitude. I think that as time went on my classmates grew up a bit, and the attitude has mellowed considerably. In the very beginning, unlike now I hope, things were not comfortable for the ladies.

Warren Bennett '47 is physician-in-chief emeritus of Malden Hospital and clinical professor of medicine emeritus at Boston University School of Medicine.

Ernest Darkoh-Ampem '98 received a BS from the University of Wisconsin/ Madison, in chemistry, biochemistry and molecular biology. Before that he came from Kenya.

Frances Nakamura '55 is a third-generation Hawaiian who grew up in a small sugar plantation village in Hawaii. But this rural isolation did not keep her from reaching her constant goal to become a doctor. Nor did her family. In fact, she got nothing but support from her untraditional family, many of whose members were engineers.

"I came from an oriental family," she explains. "In most oriental families girls are supposed to be subservient. If they do go to college, they become librarians or teachers. But my father was the original feminist." Any school would seem big and overwhelming after living in Hawaii, so her father broke her into college life slowly by first sending her to Grinnell in Iowa. While Grinnell was an exciting place for her, arriving at Harvard was, as Nakamura expresses it, "awesome."

Nakamura's awe was compounded by gratitude at Harvard's acceptance of her: "When I was looking at medical schools, many of the applications said, 'women need not apply.' Harvard was one of the exceptions. In addition to this discrimination there was a great deal of competition. She was applying during an era in which men were returning from World War II and the volume of applications was very high. Nakamura recalls little friction between the male majority at Harvard and the female minority: "The men were too busy trying to stay in school themselves, so they had no time to harass the women."

As a student of Alexander Nadas's, Nakamura was inspired to take up pediatric cardiology as her specialty. While there were very few pediatric cardiologists (men or women) at that time in the continental United States, there were none in Hawaii.

After her training, Nakamura returned to the islands only to find that "I couldn't do the things I was trained to do. There was no equipment." Fortunately, the chief-of-staff at Queen's Medical Center, who also had trained at Boston's Children's Hospital, took her under his wing. He introduced her to the Ladies Auxiliary, who in turn raised money for the necessary equipment during their annual fundraiser. "We talked them into giving us an image intensifier to replace the old fluoroscopy machine."

In addition to her work at Queen's, Nakamura also spent much of her career working for the Hawaii State Department of Health, traveling to the various islands to assess which children were in need of surgery at Queen's. She was also involved with cardiac patients from the (then) trust territories such as Palon, Tinian, Saipan and Rota.

Nakamura retired five years ago from practice and from teaching at the University of Hawaii Medical School as associate professor. She chose to discontinue any medical activities, because it is her conviction that "There is no such thing as 'dabbling' in medicine." She now refers to herself as a "plant doctor." She oversees pesticide and fertilizer applications at a relative's plant nursery. She likes to think that though she now lives in a larger town in Honolulu, she's come full circle to the agricultural roots of her childhood.

Sarah Jane Nelson

Raising

by Eleanor Shore and Stephanie Pincus

ALTERNATIVE ROUTES TO BECOMING A medical school administrator, whether a dean or department head, are numerous. Some administrators have honed their skills by taking courses in business, management or organizational psychology; others have attended workshops created by specialty organizations. Others have learned as on-the-job trainees with all the scars that go with that approach, and still others have learned skills necessary to assume a leadership role primarily from lifetime experiences.

The authors—one heads a Department of Dermatology and is the mother of three, and the other is a dean of faculty and also the mother of three—did some informal conferring and came to the simultaneous conclusion that parenting a family provides another source of administrative expertise, one that often serves well in the fray of academic administration, but one that is rarely discussed or analyzed.

One of us (SP) first came to this conclusion during an interview with the search committee for her current position as professor and chair of the Department of Dermatology of the State University of New York at Buffalo. During the process of the interview, a discussion focused on the multiple tasks of running a department, including financial management, budgeting, resident education and student education. The "off-the-cuff" response was, "I've managed a family; I can manage a department."

All administrators face the following: allocation of finite resources; pri-

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oritizing; resolution of conflicts; balancing the interests and needs of the individual versus those of the organization; accepting the dependency of those who are responsible to the administrator (learning to support and to listen to complaints); and setting limits and making difficult decisions while at the same time being fair.

One of the first realizations to strike a physician turned administrator is that the administrator's relationship with those for whom he or she is responsible is very different from the doctor/patient relationship. In a clinical setting the doctor is almost always the patient's advocate, no matter how the patient acquired his or her current medical difficulties. The medical administrator, on the other hand, has to deal with issues that affect multiple people with conflicting interests—not infrequently the final decision cannot simultaneously benefit all those involved. What better experience than parenting for learning how to distribute finite resources, privileges, time, rewards and attention to multiple applicants (children, spouses or faculty) in a manner that is fair if not always equitable?

In a family, every parent learns that some things such as pie or cake have to be divided with a mental protractor. Other things, however, such as college tuition or funding the cost of a wedding, computers and trips, have to be divided with an eye to lifetime equity. At any point in time, one child may need more resources, time or attention because of differences in age, abilities or circumstances.

Similarly, some faculty and staff benefits, such as sick leave or vacation, must be administered in a neutral and fair manner. Other needs such as career development, promotions, prizes and awards must be equally accessible, but their distribution must reflect different levels of accomplishment, different stages of professional development, different degrees of effort. Nowhere in medical school or in residency is this kind of distribution taught, but every parent has to make this kind of determination every day. The expectation is that eventually equity will be achieved, and that transient inequalities are part of the cost of family or departmental membership.

A department head must also assist the professional development of students, residents and junior faculty members with widely differing abilities and prior education, just as children may have inherent differences in verbal, quantitative or manual ability. The goal in both instances is to nurture development, while treading the fine line between too much control and inadequate support. Mistakes within limits must be allowed and choice between acceptable alternatives encouraged, skills which a parent learns well. Most parents and administrators learn to perfect "the illusion of choice."

Given that candid feedback is valuable for every administrator, the parent has a head start. Children have the most highly developed capacity for giving instant feedback, with their own clear determinations of when the unfairness threshold has been crossed. When the first faculty member shouts foul, the parent-administrator already has a thick skin and is more than ready to enter into active debate concerning relative merits, historical precedent, sequence of precipitating events, etc. The parent-administrator also has learned how to keep a mental log of pertinent events and distributions to assure that the accusation of unfairness can't stick.

Although there is a stereotype of administrators as aggressive, masculine and heartless, in fact there is a growing recognition that an effective leader needs to be able to listen carefully and sensitively to the needs and problems of those reporting to him/her. And leaders must be ready to support, encourage and accept the fact that the staff are dependent on him/her in very real ways.

Administrators also must focus on long-term growth rather than instant perfection, and create an environment where individuals can feel safe enough to take risks and extend themselves to do more in their job over time. This environment is identical to the one that parents strive for as they work through the day-to-day crises and setbacks on the way to each child's maturation and independence.

For physicians, the inevitable staff conflicts that must be dealt with pose particular problems. The leader must learn how to negotiate and mediate: skills that are never taught in medical school but that experienced parents have already mastered. At times, truth and exact causation cannot be determined, because each child did some-

thing because of what just happened to him/her, and so it goes backward ad infinitum. There may be a point where cause (and its remedy) must take a backseat to finding some resolution that is reasonably satisfactory to all participants. This resolution must be perceived as fair to all participants; no group of combatants is more practiced at ferreting out fairness than siblings who are squaring off with each other and with a parent.

In order to maintain any level of equanimitas, most parents have become expert at citing written law, common law, precedent and pertinent regulations within the family. Every one of these skills is of inestimable value in medical administration. But when pushed to it, both parents and leaders must be able to quell rebellion with, "Because I am the one who is responsible."

From all of our experience of being physician-administrator-mothers, we put forth the following set of recommendations, which are equally valuable at home or at work.

1. For some resources (food for children; salaries, space, job assignments for faculty and staff), learn to divide as accurately as possible, to the second decimal point if necessary.

2. For special circumstances, think of lifetime equity rather than immediate equity in order to capitalize on the special needs or opportunities of individual family members or of the groups. Recognize that investment of resources may bring large dividends if done at the right time. And keep a record so that no mental lapses endanger one's credibility.

3. Develop agility and a legal frame of mind to be able to invoke precedent, written law, common law or regulation to defend the basis for a disputed administrative action.

4. Don't expect perfection in yourself or in those for whom you are the parent or administrator. Be prepared to make mid-course corrections on a frequent, if not daily, basis.

5. Be prepared to expend stored-up fairness capital on a firm "no" when necessary.

Just as a parent derives satisfaction from the first steps, the administrator must to some extent be satisfied by small gains. Ultimately, both administrators and family managers will be remembered by the success of their progeny.

Eleanor Shore '55 is dean for faculty affairs for Harvard Medical School.

Stephanie Pincus '68 is professor and chair of the Department of Dermatology at SUNY Buffalo.

Leila Borenstein Liebman '58 was such a private person that it seems a violation to probe areas of her life about which she rarely spoke. But if only because she was also compassionate and concerned about, in fact experienced, the evils in the world, we will share her story as another reminder of what should never ever be.

Liebman didn't attend medical school reunions, she kept up with very few classmates, but she chose to leave a lasting legacy. When she died on November 26, 1993, she bequeathed almost $500,000 to establish a scholarship for HMS students "who wish to use their medical education to help children." Behind this generosity is the story of a woman who lost part of her own childhood, but who as a pediatric psychiatrist was determined herself to help children.

Born in Lodz, Poland in 1930, Leila Borenstein was not yet 10 years old when a dark shadow started to cast itself over her world; her family and other Jews were sequestered behind barbed wire in the "ghetto." Four years later, with her parents and two sisters, she was transported to Auschwitz, where she was separated from them and was the only one to survive.

Years later when in analysis as part of psychiatric training, she forced herself to reconstruct a diary. She wrote of the tears her father shed as he said goodbye, her "mother's face—as gray as her coat—etched in stone." The days when she found she could not speak; only guttural sounds came out. Standing naked in lines. Whips. She figured she was in

Auschwitz five weeks, but they were very long weeks.

The first week she was selected and held in a cell for "experiments," but by some fluke, was released hurriedly because the doctor who was supposed to come had had an accident and didn't show up. She wrote of her friendship with the four other girls who shared one bed ("a bare wooden platform on which we slept spoon fashion, closely huddled together"), and their speculations about who of their loved ones might survive. One of these friends, Fela, pulled her unconscious from a transport train amid bombing and saved her life—a friend she never saw again to thank. It was in a German hospital where she lay with massive wounds to her head, lungs and arms that Russian soldiers wearily arrived to liberate the city.

At a school for orphans run by UN relief workers in Heidelberg, she met Hannah Starkman, one of the few friends she stayed close with throughout her life. There they all tried to readjust to a normal life. "Youth have a way of rejuvenating themselves," recently explained Hannah and her husband Roman Kent, who was also a child survivor of the Holocaust. "There, Leila was outgoing and fun."

Hannah and Leila were on the first ship, the *Marine Flasher,* that brought refugees from Europe to the United States in 1946. Hannah went on to relatives in Detroit; Leila was taken in and subsequently adopted by Rabbi Joshua Loth Liebman and his wife, Fran Loth Liebman. Rabbi Liebman, of Temple Israel in Boston, was known to millions across the country because of his weekly radio broadcasts and his just-published best-seller, *Peace of Mind.*

Leila was very close to him: "They had a wonderful chemistry and could talk on the same mental plane," says Hannah Kent. Among his friends were scientists, senators, authors, actors and religious leaders of all faiths. But when she was in college at Antioch in 1948, he died unexpectedly at age 41. It was a devastating blow for her, and she moved home to take care of her adopted mother—to whom she hadn't felt very close—and finished at Boston University.

She then went on to medical school at HMS, to become the doctor her biological mother had wanted her to be. Being a doctor also appealed to her, says Kent, because she was determined to be independent.

She was one of only ten women in the Class of 1958, and "she was a real character," says Joseph Burnett '58, who is now chairman of dermatology at the University of Maryland. "She lived in the Somerset Hotel and took taxis to class. Leila was always smiling and I found her very uplifting." He also recalls that she used to regale them with stories about the actors she had met in Hollywood. When Humphrey Bogart came to the MGH before he died, she introduced some of her classmates to him.

Another classmate who kept up with her through the years is Anita Herald '58, who remembers her tremendous sense of humor and her concern about the issues of the world. "She was very empathetic; everybody liked her." Short in stature, with reddish-brown hair and freckles, she is remembered too for her sense of style: "She was a marvelous dresser," says Herald.

During medical school, she fell in love, got engaged and had even printed the invitations, when her fiancee's mother put a stop to the marriage because she was Jewish. "I think this on top of her adopted father's death really changed her," says Kent. "She became a much more private person."

She had other relationships, but never married. "She had seen what happened to children of war and feared raising children in a world that hadn't learned the evil of killing and slaughter. Her way was to try and help individuals."

She did her residency training at Johns Hopkins and Yale, followed by two years of training at the Judge Baker Guidance Center at Children's Hospital. (Kent believes that part of the reason she became a child psychiatrist was because of the loss of her younger sister. Before being sent to the ghetto, their nanny had offered to hide the girls, but Leila refused to go with her and so the sister wouldn't either. Her sister was immediately selected for the gas chamber and their mother went with her so she wouldn't be alone.)

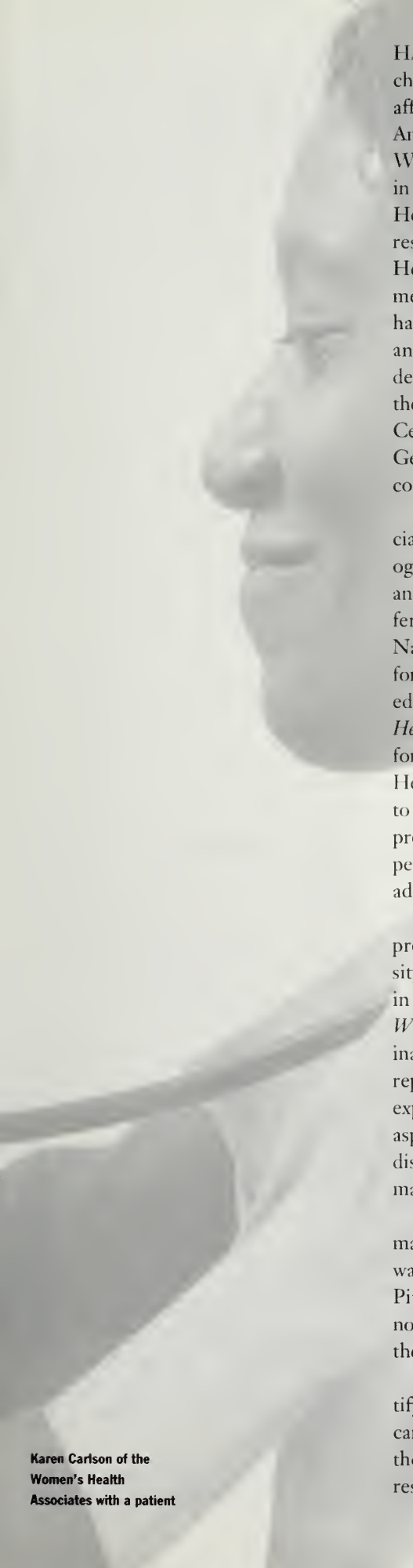
Liebman moved to Berkeley, California in 1963, where she remained as a staff psychiatrist at the East Bay State Mental Hygiene Clinic and in private practice of child psychiatry in Orinda. "She had a soft touch for children," says Kent. "If their families couldn't pay, she didn't charge them." Before she became sick with thrombocytosis, she used to also volunteer in a soup kitchen. She was an avid reader and a whiz at the *New York Times* crossword puzzle. And no one could beat her at scrabble, say the Kents. She also loved the theater and when she visited the Kents in New York City, they would take in three or four shows. And though there were days in her life she had what she referred to in her journal as "one of my forgetting to eat days," she also liked good food and wine.

Though Leibman suffered much emotional and physical pain during her life, she devoted her life to helping ease the pain of others. In the words of her adopted father, published posthumously in *Hope for Man,* "In this mysterious universe man and woman have been placed to unravel the skein of their terrestrial destiny, to spin out the threads of surprises, exaltations, miseries, all intermingled in the silken tapestry of being.... Yet we can create an unconquerable human spirit that proclaims, in spite of all and through it all, that 'life can be made worth living'."

Ellen Barlow

To Her Health

photo by Margaret Lampert



Karen Carlson of the Women's Health Associates with a patient

HALFWAY INTO THE 1990S, A SEA change is occurring that promises to affect the future of women's health. Among such developments as the Women's Health Initiative launched in 1991 by the National Institutes of Health, the publication of initial results from the ongoing Nurses Health Study, and the FDA requirements to include women in drug trials, has been the debate on the necessity and feasibility of a medical specialty dedicated solely to women. In 1992, the University of Illinois at Chicago's Center for Research on Women and Gender sponsored the first national conference to explore the issue.

"We have a women's health specialty, which is obstetrics and gynecology," argued Florence P. Haseltine in an issue of *JAMA* announcing the conference. Haseltine is director of the National Institutes of Health's Center for Population Research and senior editor of the *Journal of Women's Health*, the publication of the Society for the Advancement of Women's Health Research. "I'm willing to listen to arguments and to help the ob/gyn profession make needed changes, but I personally think these problems can be addressed by exisiting disciplines."

Karen Johnson, assistant clinical professor of psychiatry at the University of California, offers a counterpoint in a 1992 article in the *Journal of Women's Health:* "Most internists have inadequate knowledge of women's reproductive health, extremely limited experience with the psychosocial aspects of women's health care, and a discipline that is built entirely on a male paradigm."

Warning against isolation from the mainstream, Michelle Harrison, who was then at the University of Pittsburgh School of Medicine and is now in the corporate sector, wrote in the same issue:

"To create a new specialty, to certify those physicians trained to take care of women, would allow the rest of those in medicine to feel absolved of responsibility for addressing the needs of women and more inclined to leave sensitive care of women to those few practitioners who are now the 'experts'."

Marcia Angell, executive editor of the *New England Journal of Medicine*, in a 1993 *NEJM* editorial calls for balance: "Yes, women should be included more often in clinical trials, but not according to a formula that would make clinicial trials more difficult than ever and probably be counterproductive in terms of learning about differential effects in women." Angell, too, suggests that separating women's health off into its own little corner would "marginalize the care of women" and even "officially sanction" the lack of care for women in the mainstream. "If there is to be separatism, I would prefer a new specialty of men's health, leaving the mainstream to women," she quips.

The women's health care debate grew out of a dissatisfaction with a health care system believed by women patients and practictioners to be inadequate in serving women's particular health needs. Clinics and primary care practices primarily dedicated to serving women have also evolved as a means of alleviating these inequalities.

Below, two of Karen Johnson's medical students at Stanford discuss why they believe a specialty in women's health is essential for providing health care to women, and an HMS student takes issue both with the male body as the norm in the textbook, and also at the podium.

Also included in this section are examples of two clinics for women: one that provides a service not easily found in standard medical care, and the other, a women's health practice that looks at the whole person, not just an isolated ailment.

TLR

Students Support a New Specialty

by Ellen Schur and JoDean Nicolette

AMONG THE CHANGES THAT HAVE been debated since national attention has focused on restructuring health care is a new emphasis on providing health care services better suited to the needs of women. In the past, the medical community has failed to recognize the gender specificity of organ systems, and the distinct biological and psychosocial needs of women. Although consensus exists in the medical community that the care provided to women is less than optimal, disagreement exists as to the means by which to improve such care.

Several possibilities have been proposed. The current administration, under the FDA, for example, has mandated that all clinical research provide more gender inclusive information, and in 1991 the National Institutes of Health, under the direction of Bernadine Healy '69, launched the Women's Health Initiative. In order to match strides in research, many proponents of women's health have also proposed various improvements in clinical training.

Several institutions have taken the initiative and remodeled their curricula and postgraduate training to more thoroughly address issues in women's health. For example, Medical College of Pennsylvania has attempted an integrated curriculum by introducing women's health issues in every facet of their educational process. Stanford, while encouraging its faculty to discuss women's health issues in all forums, has created a focused experience in the form of a clerkship for medical students.

Einstein, Boston, Cornell and other universities have developed women's health residency and/or fellowship programs. The American Medical Women's Association has created a Continuing Medical Education program that focuses on women's health across the life span. And leading women's health advocates, such as Karen Johnson, clinical scholar in women's health at Stanford University, have debated the benefit of a primary care specialty in women's health.

As medical students we would like to address the creation of a women's health specialty from our vantage point. This complex debate has been waged almost entirely among established physicians, whose attitudies towards a new specialty are shaped by their own early specialization, economic concerns and grounding in current systems of health care delivery. In addition, acknowledging the need for a new specialty requires that physicians reflect, perhaps uncomfortably, on whether their own practice provides women with the best possible care. Medical students, however, have an entirely different perspective.

Increasingly, the prospect of becoming primary care physicians serving the unique health care needs of women draws dedicated individuals into medicine.

Our generation of medical students has had diverse opportunity to study and work with women through unique undergraduate experiences, such as courses that explored gender issues offered disciplines as diverse as psychology, sociology, history and women's studies. We wrote papers on the portrayal of women in literature, women in organized religion and women in history. We researched health topics such as teenage pregnancy, eating disorders and exercise physiology. Our interests in women's health have expanded and solidified through work experiences and pursuit of graduate degrees: including employment in clinics serving women's general and reproductive health, research on women's health issues in the United States and abroad, and positions in agencies serving women, such as battered women's shelters and rape advocacy groups. Now we have come together from diverse backgrounds to pursue medicine.

And yet, once we arrived at medical school, instead of finding a continued opportunity to focus and build on our bases of expertise, we were faced with unexpected difficulties in pursuing our career goals. The possibilities of ob/gyn, family practice, internal medicine or psychiatry fall far short of the training we desire: comprehensive, interdisciplinary training in women's mental, reproductive, and nonreproductive health.

The proposed women's health spe-

cialty, on the other hand, takes a holistic approach. The greatest disservice that medicine has dealt women has been compartmentalizing their care. A women's health specialty would create an interdisciplinary training cutting across ob/gyn, family practice, internal medicine and psychiatry.

As women's health specialists, we would eliminate the need for a woman to see several physicians just for health maintenance, or to elucidate the cause of symptoms, such as abdominal pain. Basic procedures traditionally housed in both internal medicine and obstetrics and gynecology would be combined with comprehensive instruction in psychiatric and physical evaluation training. Currently, no single specialty trains practitioners in such varied aspects of women's health as colposcopy, assessment of depression, and management of cardiovascular health. This model would not only reduce the cost of seeing multiple specialists, but would enhance continuity and trust between doctor and patient.

In addition, the women's health specialty is grounded in a wellness model. Within the prevention-oriented setting of women's health, we hope to further develop strategies of education and intervention that take into account the range of emotional, time and lifestyle factors influencing women today. For example, women's health physicians would acknowledge how an issue such as body image can affect something as simple as implementing a diet and exercise program. How women view their bodies can be an obstacle to the initiation of exercise programs even when health is at risk, or alternatively can lead to a dangerous obsession with exercise.

Finally, many of us are excited by the possibilities that a primary care specialty in women's health offers to view our patients' health within a broader social context. Reproductive choice, violence and racism profoundly impact women and are inextricably tied to improving their health: through access, treatment options and psychosocial interventions in response to physical symptoms. A specialist in women's health would be explicitly trained in identifying, for instance, chronic, vague complaints as well as bruises and broken bones as symptoms of domestic violence, as well as how to utilize community resources.

More is at stake, however, than the aspirations of future practitioners. It is necessary to address the physician's primary goal: to best serve the community by ensuring that health care consumers have a voice. Laywomen of all racial, ethnic, sexual-orientation, age and socioeconomic groups deserve to voice their preference in health care delivery. By allowing women their choice of practitioners, including primary care specialists in women's health, they will dictate to us in the medical community how we can best serve them.

We appreciate the opportunity to mark the 50th anniversary of the admittance of women into Harvard Medical School with a reminder of the

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The 70 kg Myth

I am a member of the first class with a majority of women at Harvard Medical School. It's been an incredible experience and a very different one than I think that many of our alumnae had when they were here. But there are still issues. I walk in every day and sit in class with 47 percent men and 53 percent women, but when I made my decision early last summer, selecting Harvard over Stanford, I was working at the NIH in all-male lab. The director of the lab was a Harvard medical graduate and his first comment to me was, "So you've decided to take on the old boys club!"

The men and women in my class are concerned with the issues that face not just women, but us all as parents, and the changes that are going to be necessary in the medical profession to accommodate the dual roles of couples.

Recently when American Medical Women's Association sponsored a feedback session here concerning women's issues in the preclinical years, 70 men and women of the first-year class attended. We had a two-hour discussion, during which we filled three chalkboards with issues that we wanted to see addressed. Many pertained to insufficient women faculty. Our first three blocks, which ran from September through Presidents' Day, only had four women faculty lecturers. During our last block (Dean Federman is part of this block) we've had a large number of incredible women faculty.

It is something that affects us. We may have over 50 percent women sitting in our class with us at this time, but we are most critically aware of imagining ourselves 5 years from now, 10 years from now, 20 years from now: What will we be doing? Can we do it? Faculty members and alumnae role models are critical in helping us to know that we can do it and it can be done very well. Not to say do it all, but that you can get out there, you can play hardball, and you can make it happen.

We are also addressing women's issues in the curriculum and making sure that we are not teaching medicine solely on a male-based system. For example, the 70 kg man is not the norm, and 50 percent of the United States is not a 70 kg man. I think it's pretty obvious, but not in lectures that have been the same for years.

HMS may not have been a leader in accepting women into the medical profession, but I hope that we'll make sure that Harvard is a leader in accommodating men and women in their pursuit of the medical career for the future, providing the full range of opportunities and choices.

Ann Bryant '98 helped coordinate the women's celebration symposium, during which she spoke on the panel of alumnae and students.

Suzanne (and by default, Robert) Fletcher '66 are the ultimate class couple. They met at Introduction to Clinical Medicine the second week of medical school, were engaged by Christmas and married by the end of first year. Their careers gravitated in the same direction to the point that they have been co-chiefs of the same departmental division, co-authors of a text on clinical epidemiology and co-editors of the *Annals of Internal Medicine*. They are now both HMS professors of ambulatory care and prevention, based at Harvard Community Health Plan.

Suzanne Fletcher says that they never strategically planned their professional careers to be so parallel and quips: "I blame getting married at the end of first year for why we ended up working together. With the same last name in second year, we were lab partners practicing blood tests and putting NG tubes down each other."

She was less certain of her specialty choice than her husband, but figured internal medicine was an appropriate start. Though they were strongly advised to go into different specialties—she into pediatrics and he to surgery—they matched together in internal medicine at Stanford. "This was very unusual at that time because there weren't too many women and few programs would consider a couple."

But in fact, couples were more than a mere exception under Saul Rosenberg, their program director, whom she describes as "one of the great unsung heros for women in medicine." Six of the interns in his program that year were married to each other, proving that he wasn't joking when he used to say: "If you get a good woman, if she's married, you also get a good man."

At one point on a community hospital rotation, Fletcher and three other women assigned to it were all pregnant. ("Saul didn't think this was unusual.") He allowed those who were pregnant to schedule the harder rotations early in their pregnancies. There were no complaints from the others about unfair treatment, because everyone worked hard, she says; it also helped that four of the men in the program were married to these women!

After three years in Germany for Robert Fletcher's service in the army (she was a civilian physician and researcher at the University of Ulm), they were both accepted to Johns Hopkins' then-new clinical scholars program, which put them on the track for general internal medicine and clinical epidemiology. This Robert Wood Johnson program is credited with making the nascent specialty academically sound and research-oriented. It was also where they met Tom Inui, who was to recruit them 20 years later to his new HMS Department of Preventive Medicine and Ambulatory Care.

The Fletchers were at McGill from 1973 to 1978 and then the University of North Carolina from 1978 to 1990. There they were co-chiefs of the division of general medicine and clinical epidemiology and together with colleagues wrote *Clinical Epidemiology: The Essentials* (Williams and Williams 1982, 1988). They were involved in establishing a professional society—the Society for General Internal Medicine—for this growing discipline when, the year Suzanne Fletcher was president, talk turned to starting a journal. Steven Schroeder '64 is credited with the "wouldn't it be interesting if..." idea that led to the Fletchers editing the new *Journal for General Internal Medicine*. They quickly gained the experience that made them naturals for their selection, in 1990, as co-editors of the *Annals of Internal Medicine* for four years.

Fletcher acknowledges that much of their thinking and discussion even at home revolves around medicine, but she doesn't feel this has insulated them. They have traveled around the world and camp, ski, garden and sail. Neither of their two sons has gone into medicine, per se, although John, 27, is getting a PhD in psychology and Grant, 25, is doing health sciences research.

In 1993 the Fletchers wrote an editorial "Here Come the Couples," pointing out a persisting trend from the past when there were relatively few women in medicine compared to now: about 85 percent of female physicians marry and of those, half marry other physicians. Now that women make up almost half of students entering medicine, over time, medical couples could constitute a large percentage of physicians. "No doubt this will revolutionize medicine. I see it beginning to happen already."

Even if only in passing, the Fletchers often see each other during the work day. "The powerful centrifigal forces on a marriage when both are busy and consumed by their work are somewhat balanced in our case because we spend a few days a week riding to work together. Commuting is a time when there is not much to do except talk and talk is good for a marriage."

She believes they have been incredibly fortunate because although they've had tough times, they have both been highly successful. "Although our kind of life would not work for some couples, it certainly has for us."

Ellen Barlow

impact of medical students on the future. It is our hope that physicians will continue to recognize the importance of bringing the perspective of medical students into many debates.

In regards to the proposed specialty in women's health, we urge the medical community to consider the situation in this new light: bright and motivated young people are coming into medicine with backgrounds unique to our generation. Our diverse experiences have provided us with the expertise to enter research, academic and clinical medicine, and the dedication to offer conscientious care to all populations of women. As women's health physicians, we would not only bring our expertise to our patients, but to our colleagues in the medical community.

It seems ironic that simultaneous with the headlines and reports repeating news about deficits in the care offered to women, a major resource in remedying the situation—medical students interested in becoming women's health physicians—may go untapped.

Ellen Schur graduated from Stanford in 1991 with a degree in human biology, and is currently a first-year medical student at Stanford.

JoDean Nicolette graduated from Tufts University in 1989 with a degree in comparative religion, and is currently a fourth-year medical student at Stanford.

photo by Margaret Lampert

A Woman's Place

If women could handcraft a medical practice just for themselves, it might look very much like Women's Health Associates at Massachusetts General Hospital.

Developed in 1985 by Karen Carlson '80 and Albert Mulley '75, associate professor of medicine at MGH, this multidisciplinary practice is dedicated to the particular health care needs of women. "We see a woman as a whole person, not just a set of reproductive organs," says Carlson.

Part of what motivated Carlson to launch a practice for women was that as one of a handful of women physicians in a primary care practice at MGH, she was being sought out by female patients. Many of these women reported that they had received bad care from male physicians in the past and "they had a sense that a woman wouldn't do that," she says. A 1993 study in the *NEJM* provides some evidence to support their claims. Researchers from the University of Minnesota found that female physicians were much more likely to do Pap smears and recommend mammograms, a sex differential particularly evident in primary care and family practice.

Women are also generally more comfortable with a woman as their physician, says Carlson. (While currently all the physicians associated with the practice are women, one of its founders was a man, as is its current co-director: Isaac Schiff, Joe Vincent Meigs Professor of Gynecology. "It's been important for us to have men involved with this practice," says Carlson.)

Beyond providing just "basic comfort," however, Carlson says that the impetus in developing this practice came about because efforts to teach the primary care of women "fell short of what was needed," in both technical and psychological aspects. A woman's health is frequently reduced to her gynecological parts: her need for birth control, her risk for sexually transmitted diseases and pregnancy testing. Yet treating the whole person also means responding to a woman's psychological needs, says Carlson. "We see women in a developmental way, where a

woman is in her lifecycle."

Taking a medical history here includes asking questions about the woman's psychology, not just her physiology. But, says Carlson, "we do it in a low-key and informal way." Women suffer disproportionately from conditions such as depression and eating disorders, whose roots are commonly found in domestic violence situations, histories of sexual abuse or other trauma in their lives. Beyond just talking with her physician, if a patient requires additional counseling or services around such issues, she can find it here—a structure unique to this practice says Carlson.

"Multidisciplinary practices don't usually have all the providers in one place; we think it's important to have the key specialties all here."

Of course, spending more time talking with patients means longer visits and fewer patients each day: the death knell for managed care. But, says Carlson, "Research shows when more talk is exchanged, people have higher levels of satisfaction." And that level of well-being for patients does have its cost benefits as well, she says.

Attention to the "soft side" at Women's Health Associates is not to say that women don't also receive excellent medical care, says Carlson. The practice offers primary care medicine, gynecology, surgery and psychological services. A medical practice dedicated to women also works to fill in what Carlson refers to as a "technical knowledge gap" in how to approach the female patient. For example, she says, very little clinical and scientific knowledge is available on the outcomes of hysterectomy, despite the fact that hysterectomy is the most common nonpregnancy-related surgical procedure for American women, one-third of whom have had one by age 65.

"We're developing an understanding of where the constructs in medical education don't meet the reality," says Carlson.

Another advantage of being allowed to focus primarily on women, explains Carlson (the practice does have its share of male patients, as well), is that they can gain unique insight into women's "normal" health and physiology. For example, she says, almost all women and even many physicians aren't aware that for some women a certain amount of breast discharge is normal. "The disease focus of medicine creates a lack of basic clinical epidemiology of what's normal," says Carlson.

Just as their patients enjoy a medical practice specifically centered to their needs, so do the members of Women's Health Associates appreciate a work environment specifically oriented to theirs. Many of the practice's physicians work a flexible schedule to allow room for child-care responsibilities, and it's not uncommon to see sitting behind the check-in counter a toddler or two whose babysitter got sick or whose school closed for the day. "We just roll with the punches," says Carlson.

Terri L. Rutter

Making Choices

ONCE you pass by the armed guard and walk through the narrow shoulders of the metal detector and get inside the door, the surroundings resemble any other waiting room of any other doctor's office in the city. Comfortable chairs, a couch, and a couple of tables holding a variety of magazines make up the furniture. A framed print hangs on the wall. Unlike most primary care health centers, however, posters on these walls advise women how to talk to their partners about using condoms. A sign announces that the Pill can be prescribed here; please ask for information.

Today, it is quiet. Several days a week, however, a group of people convene outside the clinic. Sometimes they stand quietly, praying and talking softly amongst themselves. Other times they are loud; they scream, chant and yell in the faces of people going into the clinic. They carry signs that read "It's a Baby, Not a Choice" and "In God's Court Abortion is Murder."

Jane Doe, who graduated from Harvard Medical School in the 1970s, is a physician and administrator here. This clinic is one of the more than 900 women's reproductive health clinics Planned Parenthood operates around the country. Because Doe provides abortions along with the many other reproductive health services offered at this clinic, antiabortion protestors have "visited" her at her home, where she lives with her husband and young children. Because she literally fears for her life, she wishes to remain anonymous. She has good reason.

Five people were murdered in 1993 and 1994 by antiabortion extremists. Two of them were physicians, such as Doe, who provided abortions; another

had volunteered as an escort to one of the physicians murdered; and two were women who worked as receptionists in reproductive health clinics.

Doe enters this clinic with anxiety and fear on the days abortions are scheduled. When asked if she's ever talked to a protestor or to anyone involved in the antiabortion movement, she shakes her head. "It's too risky to talk with anti-choice demonstrators," she says. "And the possibility of its being productive is minimal." She points to surveys that say that many people believe that "it's okay" to stop abortion with force. "This movement seems to attract unstable and violent people," she says.

The base upon which the abortion debate teeters is, basically, about babies: women wanting to control when and if they have them and another group of people trying to ensure that every one conceived is born. Doe smiles when she talks about babies. "Everybody loves babies," she says. "On both sides of this issue, one thing we have in common is we really love children." (In fact, it was to spend more time with her own children that Doe left a very successful but extremely busy ob/gyn practice a few years ago to work part time at Planned Parenthood.) The difference between the two camps is how that love is expressed, she says.

The quality of life a mother gives to her children is an expression of her love for them, argues Doe. "The teenage woman coming in for an abortion isn't doing it because she hates babies," she says. Instead, she's making a choice to have a better life for her present or future children. Similarly, when a woman feels she has enough children and elects to not have an unplanned, additional one, she acts out of love for the children she has. "Her quality of life and the quality of life for her children is going to suffer if she spreads herself too thin."

Planned Parenthood—which opened its first clinic in 1921—provided medical services nationally to 2.4 million clients in 1993, to women and men. Abortion is just one service offered: 134,000 were performed in 1993, whereas 116,000 patients received HIV screening; another 10,000 came to Planned Parenthood for prenatal care; and 1.7 million women received Pap tests. In addition, Planned Parenthood offers breast exams and cancer screenings for women, while men can receive counseling and treatment for sexually transmitted diseases and in some clinics, have a vasectomy.

"A big push of the organization is for women to value themselves, to take care of themselves," says Doe. Her clinic provides information about domestic violence and abuse, sexually transmitted diseases and other issues of concern to women. But mostly, it provides contraception: 1.9 million women received contraception at a Planned Parenthood clinic in 1993. "In reproductive medicine, prevention is key," says Doe. In fact, the brochures that fill the literature rack in this clinic are predominately about birth control.

"Abortion should be incorporated into routine medical care," says Doe. It is one of the most common elective surgical procedures available, and "an abortion is many times safer than delivery," she says. But abortion has been so maligned that it is isolated from all other medical services.

As Barbara R. Gottlieb in a February 23, 1995 "Sounding Board" in the *New England Journal of Medicine* writes: "Such discontinuities make it difficult for primary care providers to track referrals, follow-up information, and outcomes for patients who undergo abortion—standard clinical practice for other medical procedures."

Many of the women who come to Doe's clinic are reluctant to go to their primary care providers either because they're not sure he or she is pro-choice, or they fear having a notation of the procedure appear on a bill that could be seen by a parent, husband or boyfriend. Instead, they elect to come to a clinic, pay cash, have the abortion and leave. "Let's hope in the future that women won't have to go outside the mainstream for contraception and abortion care," Doe says.

The recent mandate on ob/gyn residency programs to offer abortion training may be one step toward affecting a change. During her residency, Doe spent a six-to-eight week rotation just doing abortions. "It was just part of the training," she says. "It seemed pretty mainstream." In time, she hopes, everyone trained in ob/gyn may have similar experiences.

The Accreditation Council for Graduate Medical Education announced in February of this year that residency programs must include training in abortions and "clinical training experience in all methods of family planning." If the institution has a moral, religious or legal objection to abortion, it must provide opportunities for its residents to obtain that training elsewhere.

That is all good news for Doe, who will begin training residents at her clinic this year. The first thing these second-year residents will be exposed to, she says, is sensitivity training and the counseling process. "That's a part they don't get in their residency curriculum," says Doe. The technical training they will receive is only part of a much bigger picture.

When asked if she ever thinks about choosing a less dangerous place to work, Doe says no. "I think about it, but I think I would regret it. And besides, it's not the right response to terrorism."

She says she specialized in ob/gyn because it allows the practitioner to identify the patient's problem and then make a difference in her life. "What greater input can you make in a woman's life than help her determine how many children she's going to have? It's not just altruism; it's a very rewarding field to be in."

Terri L. Rutter

As an African-American member of the Class of 1974, **Gloria Singleton-Gaston '74** felt the impact of affirmative action. "I knew I deserved to be there and I appreciated the opportunity to further challenge my abilities. But I also felt the responsibility to other minority students in the future." These were internal pressures that compounded the external academic pressures.

She was always conscious of the need to excel: "It was like being in a fish tank. We were observed and we knew it. Our class was an experiment. What happened to one, happened to all." The bond that Singleton-Gaston formed not only with the class at large, but with the 20 or so African-American students living at Vanderbilt Hall—was very strong: "We have kept up with each other over the years, even today."

When asked about her perception of the current status of minorities at schools like Harvard, Singleton-Gaston is not optimistic: "I think it has regressed. When I was at HMS there was at least the general idea of acceptance. We were trying to work out our differences together. If you were amongst your peers, and so long as you did your work, you were OK. But now it seems that students are having to deal with other social issues that get in the way of learning."

Singleton always planned to return to Georgia, where she grew up, to practice. During her third year of medical residency she made it as far south as Howard University in Washington, D.C.: "I wanted to broaden my experience by working with more minority patients and professors." Upon returning to HMS she met her future husband, John, a Yale medical student, during a conference in Countway Library. They married after they each finished medical school and three years later, after the birth of their first child, she accompanied her psychiatrist husband to Yale, where she finished her fellowship in rheumatology. They eventually returned to Georgia, where Singleton went to work for an HMO.

After the birth of their second child, she came to the reluctant realization that she would have to leave medicine for a time—she ended up taking a five-year leave. Little did she expect this would broaden her horizons. "I think my time outside medicine [as a mother] made me realize that I had identified myself with my profession, that I was a doctor, which mattered more to me than anyone else. My children were happy as long as I fed them, dressed them, played with them and loved them."

Singleton, whose sons are now 11 and 14, has learned how to prioritize her time. Approximately three-quarters of her week is spent in her private rheumatology practice, while the rest is devoted to family activities. Singleton, whose sons are red belts in karate, is a brown belt and takes her discipline very seriously: "It increases my awareness and gives me a sense of security and more confidence. It also helps with both mental and physical fitness."

Singleton considers herself a businesswoman as well as a clinician. "I'm learning the business of medicine. That's important as a private practitioner. There's a lot of uncertainty in the profession and it's important to be aware of all the changes."

Sarah Jane Nelson

Daunting or Doable?

Diversifying the HMS Faculty

by Terri L. Rutter

A WEARY BAND OF TRAVELERS GATHered in 1992 and asked each other what Harvard Medical School could do about its embarrasingly low numbers of women and minority faculty. They had been selected by Dean Daniel Tosteson '49 to convene under the proactive-sounding rubric Faculty Council Ad Hoc Committee on Increased Recruiting of Women and Minority Faculty.

A few of them, however, veterans to this "cause" of low numbers of minorities and women in the faculty ranks of the medical school and its affiliated hospitals, were not as inspired as their charge suggested. They came with flagging energy to take up one more time what they had sat on countless committees in the past to address.

"I had gotten used to recreating the wheel in these committees and not making much progress," says Maria Alexander-Bridges '80, associate professor of medicine at MGH and member of the ad hoc committee.

Among the doubtful was one of the ad hoc commitee's co-chairs, Booker Bush. Bush came to Harvard from Yale in 1981 and joined the faculty in 1983. Every two to three years thereafter he, too, had sat on a committeee to look at these issues. "You can't figure out how to get your fingers around it," he says.

Yet in the midst of this seasoned group appeared a few new faces: eager, youthful, determined and most significantly, not enervated from past frustration. And that made all the difference.

"It was the strength and will of the medical students that kept us on track," says Bush, assistant professor of medicine at Beth Israel Hospital. Bush chaired the committee with Ken Arndt, chief of the Department of Dermatology at Beth Israel. "If left up to Ken and me, we would have stopped."

That drive and determination resulted in the most significant development to date in regard to issues of women and minority faculty at the

Rebecca Small '97 provided invalnable assistance in the preparation of this article by supplying backgrounnd information, helping arrange interviews with students and faculty, discussing ideas and commenting on the final draft. In addition, her enthusiasm for what the students had accomplished provided ongoing motivation.

medical school. In 1994, at its April 20 meeting, the Faculty Council overwhelmingly approved the ad hoc committee's proposal for the establishment of a dean for faculty development and diversity. Its first incumbent, who assumed his post in January 1995, is William Silen, who had just retired as chair of the Department of Surgery at Beth Israel Hospital. The story of how his position came about is built on attributes that most purely identify Harvard: elegant science; an entrepreneurial spirit; and a devoted commitment to its students. "We're reaping what Harvard was teaching us," said Donnella Green '98, MD/PhD student and member of the ad hoc committee.

Where the ad hoc committee separated from the pack of its forebears was not only due to the students' persistence but also to their acumen in presenting a clear scientific argument, beginning with "an underlying assumption of equality," says Patrick Senatus '98, MD/PhD student and member of the ad hoc committee. They argued that since no scientific evidence exists to support the idea that women and minorities are inherently incapable of performing the tasks of a faculty member, there is no scientific or philosophic reason why more women and minorities should not be members of the faculty.

From this idea, they wrote a "Statement of Commitment," which was adopted by the Faculty Council:

In an ideal world of equitable resources and expectations, the Faculty of Harvard Medical School would fully reflect the diversity of society as a whole. Harvard Medical School is committed to assemble a faculty that mirrors the diversity of our nation.

Their goal is well stated, direct, logical and no small task. According to 1990 U.S. census data, the diverse composition of our nation is 83.1 percent white, 11.7 percent black, .6 percent American Indian, 1.5 percent Asian or Pacific Islander (.4 percent Chinese and .3 percent Japanese) and 6.4 percent Hispanic. Not to mention, 50 percent of us are women.

In nearly every lecture and tutorial, they look up to see a white man presiding.

"I think it's striking that when you raise the question: 'In an ideal society, would the faculty have the same composition as the country?' the room goes silent. Now why is that the case?" ponders David Potter, Robert Winthrop Professor of Neurobiology. "If they think that women and people of color are inherently less able to handle faculty tasks, then they are going to hesitate to answer the question."

Potter offered advice, emotional support, tea and sympathy to the students. It was Potter who suggested the students utilize the Faculty Council as a forum for their proposal. "It is their role to listen and they do listen," says Potter of the council.

While the issue of the low numbers of women and minority faculty had certainly not lain dormant—"This question comes up all the time," says Potter—it was events both national and local that initiated student conversations about what they could personally do to address the situation.

In fall of 1991, what began as a casual student dance in Vanderbilt Hall ended with an act of violence and the shocking awareness that racial tension and misunderstanding were present at the medical school. In what has become known as the Halloween incident, two white students attended a party dressed as Anita Hill and Clarence Thomas—their costumes complete with black face. Although an African-American student immediately engaged these two in a conversation to explain the seriousness of their offense, another was so angered that he punched the man on the brow, causing him serious injury.

Dean Tosteson responded immediately by coordinating an ad hoc committee, chaired by Felton Earls, professor of child psychiatry in the Department of Psychiatry, to explore issues of racial sensitivity. (Daniel Goodenough, Takeda Professor of Cell Biology and master of the Holmes Society, developed this effort into a standing committee on race and diversity, which coordinates programming around these issues for students and faculty during orientation.)

That same year, four Los Angeles City police officers nearly beat to death a man named Rodney King after stopping him for a traffic infraction. When two of the officers were acquitted during their trial the next year, riots broke out in South-Central. For three days, the city of Los Angeles performed a delicate pirouette on the precipice between law and disorder and 55 people died.

In many students' minds and conversations, events at home and on the other side of the continent seemed intrinsically linked together. Their restlessness was compounded by experiences in nearly every lecture and tutorial, where they looked up to see a white man presiding. "I've never been taught by a black woman," says Green, an MD/PhD student in the Department of Neurobiology. "I'm the first black woman in my department."

A feeling grew among the students that change was needed. Members of the Third World Caucus, the Women's Health Association and the student chapter of the American Medical Women's Association banded together and petitioned the Faculty Council to renew its commitment to affirmative action.

In response, the council established the Ad Hoc Committee on Increased Recruiting of Women and Minority Faculty. It joined company with at least five committees, offices or divi-

photo by Ulrike Welsch

The student body, on the other hand, boasts an unprecedented diversity.

sions that have some aspect of minority and female faculty development as part of their mission. "The good news is that many efforts had been going on for a long time," says Clyde Evans, who as the associate dean for clinical affairs is responsible for aspects of faculty career development.

"It isn't that things haven't been tried," says Eleanor Shore '55, dean for faculty affairs. "An enormous amount of energy has gone into this."

The foundation for a full-fledged effort to create diversity at HMS had been laid in activities such as the annual career planning conferences, which are mandatory for women and minorities. While both Evans and Shore admit that the spirit in which these conferences are conducted cannot be closely monitored, they argue that many women and minorities have found them beneficial, and CPCs will continue to be an integral part of faculty development.

Last year, the Office for Academic Affairs joined with Women in Academic Medicine to sponsor a series of career development seminars targeted specifically to women. The ongoing Minority Faculty Development Program, under its director Joan Reede, continues its two-pronged effort to both create more minority physicians and to increase their recruitment to the school. In hopes that they will choose to do their residencies here, the visiting clerkship program enrolls minority medical students from around the United States into four-week electives at HMS; and the biomedical sciences career project introduces secondary school guidance counselors to representatives from medicine and biotechnology.

"The bad news," Evans continues, is that representatives from all these efforts, regardless of the impact they were making individually, "weren't talking to each other."

The need for these efforts is reflected in the statistics: in 1991, only 6.3 percent of HMS professors were women; 1.8 percent were African Americans (only 1 of whom was a woman), .4 percent were associate and 1.1 percent were assistant. Above the instructor level there were barely enough Hispanic and Native American faculty to mention: 0 Native Americans and .9 percent Hispanic professors; .1 percent Native American associate and 0 assistant; 1.2 percent Hispanic associate professors and 1.6 percent assistant.

Not only were the numbers low in 1991, says Senatus, but they had never shown any significant change: "If that trend continued, we wouldn't have any change for 500 years."

While the faculty was predominately male and white, the student body, on the other hand, boasts an unprecedented diversity: of the 170 students in the incoming class in 1994, 89 are women and 88 are minorities. In fact, in March of 1994, the school won the Paul R. Wright Award for Medical Education from the American Medical Students Association for its efforts in recruiting and retaining underrepresented minority students.

"The population is really diversified and we have to understand how racial differences affect disease," says Green. "Our patients will have different belief systems, and patients from different backgrounds have different nuances to their diseases."

HMS faculty has a history of responding to the activism of its students and around the issue of minorities and women at the school, the students have a history of being vocal. In 1850, a student petition against the admission of three black men persuaded the administration to rescind their acceptance. In 1968 students appealed to the faculty to respond to the civil rights movement, prompting it to initiate affirmative action. And in 1978, when the school considered discarding its affirmative action policies in response to the Supreme Court decision in *Regents v. Bakke*, the students successfully rallied together to convince it otherwise.

The student activism that produced the dean for diversity, however, was of a very different timbre than that of the '60s and '70s, when the words "student" and "activist" were almost synonomous and they meant banners, signs and shouting in the streets. This protestation was a mostly quiet affair, best characterized by its leader, Senatus—affably soft spoken, but focused and direct.

It was Senatus who transformed malcontented disputations among students in dinner and hallway conversations into a paper form that could be presented to the Faculty Council. He personally lobbied individual faculty members and students and sat on both the ad hoc committee and its sister organization among the student body. It was Senatus whose will kept the momentum going. "He was very persistent," says Arndt, "but in a gentlemanly way."

After the ad hoc committee had been meeting for a year, Sentaus met Rebecca Small '97, an energetic first-year student who was co-chair of the American Medical Women's Association and co-chair of the Women's Health Association, and she enthusiatically took on the role of organizing the students.

"The dearth of female role models and mentors at HMS was particularly poignant for me," says Small, who as a graduate of both a women's high school and a women's college in Cambridge University, UK, had had "exposure to outstanding women mentors."

Small and Senatus coordinated a series of events aimed at rallying student support. They composed a letter

appealing to students to talk to members of the Faculty Council and attached a list of those people. But also, and perhaps most significantly, the letter included a chart of the statistics of women and minority faculty since 1979 so students could see for themselves how low the numbers actually were.

The tour de force of this movement, however was Senatus and Small's creation of Students United for Faculty Diversity, or SUFD—an umbrella organization that brought together representatives from student organizations with such seemingly disparate self-interests as the Maimonides Society, the Asian Health Association, the Christian Medical and Dental Society, the Kinsey 2-6ers (the gay, lesbian and bisexual student association), the National Chicano Health Organization and the Catholic Students Organization. Representatives from these organizations wrote letters to individual members of the Faculty Council and to the administration in support of the ad hoc committee's proposal.

"That stack of letters," says Bush, "sent a very powerful image to the medical school."

Small and Senatus launched a highly visible awareness week before the council meeting at which the proposal was to be presented. "Pat and I camped out in the MEC," says Small, where they covered the walls with posters and lobbied individual students one-on-one.

Three speakers, known for their fervent addresses on minority and women's issues, were invited to come rally the cause: Jorge Chapa, Derrick Bell and, on the day itself, Frances Conley. Finally, Small and Senatus invited students to a "student gathering" to show support for the proposal and to greet the members of the Faculty Council as they entered the conference room in Building A.

Behind closed doors, the debate over the issue moved from the practicality and feasibility of hiring a new dean to suggestions that the money could perhaps better be spent sponsoring lectureships. Small presented a petition, signed by over half the student body, (and over 100 members of the Harvard Union of Clerical and Technical Workers) endorsing the hiring of a dean for diversity, and one faculty member called for "justice" at HMS.

"A lot of faculty spoke up: 'We don't know if this will work, but we need to support the students'," remembers Green. Finally, though, when Dean Tosteson asked for a vote, the proposal was unanimously accepted and celebrated with a round of applause.

"It's very exciting to have been a part of this historical moment, in which students and faculty really worked together," says Small. "HMS is a great institution; it values its students and it listens to them."

"The whole class should be honored for this, as should the dean, the Faculty Council and everyone who helped implement this policy," says Potter.

So what's next? "Getting the position was the victory," says Lisa Geller, instructor in neurobiology and chair of the Joint Committee on the Status of Women, who also sat on the ad hoc committee.

"Everything he does beyond that is icing on the cake." But in many cases, the cake is not yet baked.

Everyone, however, has offered suggestions. The ad hoc committee submitted ideas, such as "identify and raise funds for endowed chairs for women and minorities"; and "establish a mentoring program for women and minority housestaff." The Joint Committee on the Status of Women suggested educating search committees, rewarding departments that show progressive policies and making buildings more mother/child-friendly with built-in childcare facilities. "It isn't just women leaving early once or twice a week to pick up kids from day care," says Geller

The proposal was unanimously accepted and celebrated with a round of applause.

But nothing is easy; and little is cheap. "Right now, the funding isn't good. But there is an effort to try and get more," says Silen.

Another complicating factor is that while "the medical school has the moral authority," to make recommendations, explains Arndt, "it can't demand that anything happen in the teaching hospitals because the school has no way to enforce that."

"It's the departments in the hospitals who are all running their own show," say Evans. "We have about 60 different appointing departments making autonomous decisions."

Also, the problems for women and minorities are dramatically different: with underrepresented minorities, it's an issue of recruitment and retention; with women, their actual numbers aren't so bad, but they are disproportionately higher at the lower levels than their male colleagues.

Minorities first. The much touted pipeline problem is evidenced not only in the pool of applicants to medical school, but also in the low numbers of minority faculty members around the country.

Following the ad hoc committee's first proposal, which was unanimously rejected when it was presented to the Conference of Department Chairs, Evans spent the greater part of the subsequent summer meeting with department heads to learn why they had been so opposed. Many were concerned about one particular point: "Sanctions for not achieving intermediate goals (perhaps involving Promotions and Appointments

We ask our children: "What kind of blood do you have?" Proudly, they say: "Filipino and Chinese." "What language does your heart speak?""Sign language and music—they are God's languages, right?" "And how about your mouth?" "Oh, that's American, of course." (And it's true, they prefer pizza and hamburgers to steak and potatoes, but they also love to eat suman, dumplings and French brie.)

Yeou-Cheng Ma '77 was born in Paris to Chinese parents; her husband, Michael Dadap, was born in Leyte, Phillipines to Filipino parents. As Ma describes above, in an article she and Dadap wrote a couple years ago, their children—11-year-old Daniel and 8-year-old Laura—weave their parents' cultures and their American home into their own unique tapestries.

Ma's "complex and full life" mixes the foods and folksongs of different cultures, as well as music with medicine. She is a developmental pediatrician at the Rose F. Kennedy Center of Albert Einstein College of Medicine, where she works with children with physical handicaps and hearing impairment. She is also executive director of the Children's Orchestra Society in New York, for which Dadap, an accomplished musician and composer, is artistic director. The COS is a 100-plus member orchestra of children from ages 7 to 17.

"Born to a multilingual musical family, I remember as a toddler conducting trees in the Jardin Luxembourg in Paris, hoping they'd respond in a burst of Beethoven symphony," says Ma.

Ma's family is the embodiment of music. "The violin is an extension of my arm," she says. Her father, the late Dr. Hiao-Tsun Ma, played 200 instruments. A renowned master and teacher, he founded the Children's Orchestra Society. Her mother, Marina Loo, was an opera singer and her brother, Yo-Yo, is the famous cellist. Beginning at age seven, sister and brother performed in Paris and around the United States, including an appearance on the first telecast to raise funds for the Kennedy Center for the Performing Arts in 1962.

In October of last year, Ma brought together her love of music and her training in medicine in one remarkable event: leading the Apgar Quartet at the annual meeting of the American Academy of Pediatrics. Her instruments: two violins made in 1957 and 1959 by Virgina Apgar, who "wrote down on a piece of napkin what is now known as the 'Apgar score,' a baby's first report card," explains Ma. This concert marked the unveiling of a U.S. postal stamp commemorating Apgar.

Apgar, who died in 1974, was an anesthesiologist at Columbia-Presbyterian Hospital and played and built string instruments, including a viola made from a curly maple wood shelf she purloined from a phone booth at the Babies Hospital of Columbia Presbyterian.

"Folklore has it that the molecules of an instrument get aligned with the spirit of the player," says Ma. "Indeed, of the four instruments, this 1957 viola stands out in the richness of its sound. Virginia Apgar's spirit lives in that instrument!"

Ma migrated with her family to the United States in 1962 when she was 11 years old. Following what she describes as "various convoluted detours," which included her decision not to pursue a professional music career, Ma came to HMS in 1973. It wasn't the most likely choice for her: "I was shy and I didn't like the sight of blood," she says.

"What a cultural shock it was to negotiate the socialization from the dreamlike world of the 'warrior woman' to American society, filtered through a Radcliffe education, to initiation to the medical fraternity, which itself was adjusting to the throes of the feminist and other civil rights revolutions," she wrote about her experiences.

While the burgeoning women's movement was making its own demands for social reform, Ma says she would have appreciated a more equitable distribution of women's restrooms in the hospitals. "You had to reroute your rounds so you could get to the bathroom," she remembers. "If you had to run two blocks to go pee, you'd miss something."

Never had the restroom seemed such a powerful place, says Ma, until male surgeons conducting rounds carried a discussion of surgical technique into the men's room, of course accompanied by all the male students while the women were left outside the door. "I wanted to go in not because I wanted to see the men," says Ma, "but because I wanted to learn surgical technique!"

Music kept Ma going throughout her rigorous medical school schedule of classes and clinical rotations. She and other dedicated student musicians continued to play music: "Our need to play superseded the need to sleep and eat."

"What I'm most thrilled about is that I've integrated my life," Ma says now of her three-days-a-week medicine, seven-days-a-week music schedule. And while medical school was difficult—like "walking onto a football field without knowing the rules"—Ma says she loves what she is doing now. In her work with developmentally disabled children she sometimes uses music to reach them. She describes singing with one of her patients, who is severely retarded: "It helps me get a hold of the kids' view of the world."

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Committee)."

"I was told story after story where people had not only been aware of this issue and tried to do something about it, but...were very pained by their lack of success," says Evans. "I was unaware of the lengths to which some people had gone and had nothing to show for it."

Evans tells of one department that aggressively tried to recruit an African-American professor, only to have the candidate in the end choose to go elsewhere. "The reason that one hurt so much," he says, is because it was in pathology. When that recruitment search was initiated, there were only eight African-American pathology professors in the entire country. Today there are nine.

"We're a relatively small community trying to bring about change to what is, to a good extent, a societal problem," says Arndt.

But Potter deemphasizes the power of the pipeline. "Of course that's literally true that there are fewer minority and female faculty. But with a faculty focused on leadership, the argument can't stop there," he says. "White male faculty have to face that their task is to, essentially, replace themselves with a woman or person of color."

Alexander-Bridges argues that the school needs to try harder to "create talent from within," and suggests that mandates "would make this go quicker [because such tools] really make people think seriously about how to develop the talent they need."

For women, it's less a question of numbers. As statistics presented during the celebration of the 50th anniversary of women at HMS revealed, the percentage of women assistant professors has shot up dramatically in the last 15 years, from around 10 percent in 1980 to upwards of 25 percent in 1994. Above that level, advancement to the associate and professor levels has definitely occurred, albeit less vigorously.

It's during the time that those wanting to make it in academic medicine need to be their most productive—publishing papers, combining research, teaching and clinical responsibilities—that women often begin having children: this either removes them completely from the track for a while, or alters their schedules enough so that the full-timers around them rise to the next level at a faster pace.

"We're a relatively small community trying to bring about change to what is, to a good extent, a societal problem."

"That's where we're going to put our magnifying lens for women," says Shore.

To assist women through the crunch times afflicted by the convergence of work and child-care responsibilities, Shore has spearheaded a campaign to establish a $3 million fund. Women who qualify (although the fund will not be limited exclusively to women, men who apply will need to show a hardship in the same areas) will receive financial assistance to fund protected time to concentrate on their research or to hire a lab assistant, etc.

"The most frequent recipient will be a woman with small children," predicts Shore, although older women caring for aging parents or faced with similar responsibilities may also be included.

All eyes will be looking towards Silen to see how he will bring this myriad of efforts together and also develop strategies for the future. While many acknowledge his task is daunting, as someone whom Bush admirably refers to as a "grand old man of medicine," he already has the confidence of those watching. "If anyone could succeed at what we wanted, he was it," says Bush.

Silen's name appeared at the top of the list of possible appointees. The ad hoc committee knew it needed someone who not only looked like the majority of department heads, but could also, as a full professor and a former chair of a department, look them in the eye and say "Let's do it." Silen was also well known for his success in diversifying his own house as chair of the Department of Surgery at Beth Israel Hospital. He hired women surgeons when heads of departments elsewhere didn't believe women possessed the mental or physical capacity to do surgery.

"I don't think he made any great fuss about it, he just did it," says Arndt.

But is one man, even a very good man, enough? Goodenough is not subtle in his doubts and frustration. "It lets everybody else off the hook," he says, speaking about those who may adopt the attitude: "Go talk to Silen; that's his bailiwick. I don't need to think about it."

In spring 1994, Goodenough, along with a small group of faculty and students, participated in an intensive weekend retreat conducted by Visions, Inc., an organization that conducts diversity training. Through workshops, counseling sessions and various other activities, this group explored the complexities of developing diversity within an institution. "The faculty doesn't know how to value a different kind of creativity," says Goodenough. Harvard Medical School, he argues, needs to learn "what a multicultural community is all about."

Goodenough has suggested that the school contract with an organization such as Visions for an extended period of time and require everyone—students, faculty, staff—to participate in training in diversity. (Currently the school does offer periodic trainings around issues of diversity, but not on a mandatory basis.)

"Everybody is involved; the community takes a giant step and everyone has the same language," he says.

With all good intentions and people in place, will Harvard really change?

With all good intentions and people in place, however, will Harvard, in the final analysis, really change? Is it able? It is not a place to which one easily receives an invitation; and once here, it's not always warm and cozy. "People who stay are routinely mistreated, not just minorities. People here are in steep competition," says Alexander-Bridges. "It's not a welcoming place if you're waiting for someone to hang out with you."

"This is an environment that attracts and nurtures a certain kind of person, and not everyone thrives," says Evans. "I can tell you that there are plenty of white men here who are unhappy and who would probably be better off someplace else. But they don't get the attention and the press."

Green is not staying once she finishes her degree in 1998. Although she admits that part of the reason is the chilly New England weather—Green hails from the more temperate Virginia/D.C. area—she also says she needs to go somewhere where she can focus primarily on her research. "I don't want to be the head of affirmative action at HMS," she says.

While Evans regrets decisions like hers, he is confident about the prospects of having one person whose mission is to abort such attrition in the future. His sentiments are echoed throughout.

"It's going to take a little while," says Senatus. It took a generation to get to the student level; it will take a generation or more to get to the faculty level. But if you don't start now, it just takes longer."

Potter, too, has faith: "I have a very high regard for this faculty. I think basically they are very serious people, proud of their past performance, proud of their devotion to getting things right, to not blowing it," he says. "The faculty is not perfect. If it were perfect, it wouldn't have been left to the students to have this discussion. But it will rise to the occasion."

And Dean Silen, on whose docket now it all rests, gives them reason for confidence. "I'm hopeful," he says. "I wouldn't have taken on this job if I felt it was totally impossible."

Terri L. Rutter is associate editor of the Bulletin.

Long before **Andrea Halliday '86** became one of a very few female neurosurgeons in the country, she was making headlines in her local newspaper in 1972 as the first woman in northern California to do tuneups and pump gas in a filling station. How she broke through one male occupational stronghold into another is illustrated in a resume filled with steam, sheep, and a few good men.

"I always felt that if I wanted to do something, was interested in doing it and thought I had the talent for it that I should do it," says Halliday, who is now an assistant professor of neurosurgery at University of New Mexico in Albuquerque.

A favorite uncle introduced the teenage Halliday to the inner workings of a car's engine. She discovered an affinity for working with her hands combined with the thrill of the mental challenge—skills that would translate well into performing surgery. "It's a similar set of problem-solving skills; you have something that's not working properly...and you see if there's something you can fix."

Well before holding a scalpel, and a couple years after maneuvering a tire iron, Halliday went to Stanford University, where she says she had "a sort of Rennaisance, broad liberal arts education." It was there, too, that she developed her interest in the neurosciences while working with neurosurgeon Karl Pribram, who was conducting cognitive psychology research on lesion-induced deficits in the brains of monkeys.

Following graduation from Stanford with a degree in philosophy and neuropsychology and faced with large school loans, Halliday applied plumbing skills she had acquired while helping a friend build a house toward a job as an entry-level steam plant mechanic—a position, she says, that "paid more money than the highest level secretarial job." There, again, she broke the sex barrier, although another woman was hired shortly afterwards.

After two years she contemplated entering an apprenticeship program to become an instrument mechanic, but decided she wanted something more people oriented so went to the University of Washington to pursue graduate work in philosophy. After a while, however, she grew dubious about the wisdom, or futility, of dedicating her life to studying philosophy: "I began to wonder if all the philosophers dropped off the face of the earth what difference it would make," she chuckles.

She thought of a way to combine her desire to help people and also use her mechanical skills: become a doctor. Her decision necessitated putting herself through school again, this time to complete premedical requirements. This move prompted another unlikely occupation: working on a sheep farm herding the sheep, raking out the barn and repairing fences. "I could do the work at dawn and dusk and go to school during the day," she says. Subsequently, she worked at the Fred Hutchinson Cancer Center as a ward clerk.

"And then I ended up at Harvard Medical School."

Halliday eschews the label trailblazer: "I did a good job and I was recognized for the job that I did and that's the way it should be."

Although she feels that she was never singled out or treated differently because she was a woman, she does believe that the pressure is harder for women. "If you're not as good, then other things start to be more important, like the fact that you're a woman or the color of your skin and other things that people may or may not like about you. But as long as there's nothing they can criticize about the job you're doing, those things don't take on importance."

Also, she says, things for women are changing. Halliday harkens back to her years as an undergraduate when the new gymnasium Stanford built in the early 1970s didn't include a women's restroom. When she was in high school, before Title IX passed—which in 1972 mandated equality for women and girls in educational institutions—she and her teammates on the girls' basketball team had to practice at 5:00 AM because the boys had the gym after school. "It wasn't even an issue of fairness, that's just how it was," she says. "So things have come a long way."

Things are changing for women, she says, because more women are out in the working world, and also because men's attitudes are changing. "Now you have men whose mothers are professionals who are coming through college and medical school."

When asked if she considers herself a mentor for other women, Halliday, whose own mentors were all men, again underplays her pioneering role. "I think the fact that I exist and that people are aware that I'm here" will influence women.

"It's going to take time to change; it still has a long way to go," she says. "The only way it's going to continue changing is if you see women in places where you didn't see them before."

Terri L. Rutter

Towards True Equality

by Lisa Guay-Woodford

I FELT A SENSE OF DISCOMFORT gradually building inside me as a I listened to the young woman develop her thesis. The occasion was the Women's Dinner during the HMS alumni week. We were seated in the Building A faculty room, clustered in tables of eight. The mood was celebratory. I had left the Harvard system just six months before, and it was great to be back, to see old friends, to be part of this celebration with so many accomplished women. But I was experiencing a gnawing discomfort.

Over the past months, I have periodically revisited that evening and tried to tease out the etiology of my discomfort. That first-year student had spoken so eloquently about her mother's struggles at HMS a generation before: a struggle for an equal chance, for respect and for gender-blind acceptance. The message was one of hope and strength and the will to overcome obstacles. I smiled at the daughter's respect for her mother and her mother's generation. (My daughter is three and one-half.)

The woman compared her own experiences with those of that previous generation. She spoke of more subtle slights, of persistent gender inequalities and of men who profess understanding but all too often fall short of true insight. She argued that we are not yet equal in the eyes of medicine or indeed, the society at large. The struggle for equality must continue, she urged. We must remain vigilant and not tolerate actions or words that in any way diminish our talents. The HMS students at my table echoed her words and her passion.

To a certain extent, I agreed with these women that night and I continue to agree. While I have not experienced the sharp sting of blatant discrimination, I have endured too many episodes of irksome sexism. Sales representatives have left their cards for me to pass along to "my boss." Plumbers have offered to call my husband to explain a problem with our PVC piping. Colleagues have derided my consensus-building style as too soft to be effective. Neighbors have, in one breath, lamented how hard their physician-husbands work and, in the next, chided me for not participating in neighborhood luncheons.

So, why do I feel discomfort with the students' remarks instead of solidarity? Simply put, while I agree with the issues, I do not completely buy the proposed course of action. I know that gender inequalities persist, but I do not view men as a collective foe nor do I think every transgression deserves the same forceful response.

In part, my views are derived from my personal experiences. Just as easily as I can recall the slights, the put downs and the irritations, so too I remember the support. When as a child I announced that I wanted to be a doctor, my parents took me as seriously as they would a five-year-old son, and they continued to do so throughout my childhood. In high school, a male teacher provided me with invaluable support at a time when being a girl and loving science were virtually incompatible with life. And on and on through college.

If I had to choose one single reason that I came to HMS, it was because my husband patiently and persistently encouraged me to overcome my self doubts and make a choice based on the best potential opportunity. In short, along the way, my life has been touched by both supportive men and women.

Thus for me, the issues of gender equality are not exclusively black and white but rather shrouded in hues of gray. While discrimination and exclusion are absolute evils, in my personal experience, everyday life has presented challenges that are typically more subtle. I have been subjected to sexism, but I have not been constrained. My destiny both personally and professionally lies squarely in my hands. Unfortunately, this is not true for all women. Therefore, when I raise my voice in outrage about sexism, I think that it should be directed against acts of discrimination that are limiting, demeaning or abusive.

For example, I agree that the current vogue of bashing intelligent women shares a common root with the physical and emotional abuses that continue to be inflicted upon so many women. The point in each instance is to deny women power. But insults are not equivalent to physical and emotional blows. Irritation is not synonymous with domination. To me, how one counters a derogatory remark is a matter of individual style. In contrast, acts of subjugation are a very different matter that often require legal restraints and demand social outrage.

My point is that sexism has a myriad of faces and manifestations that range from the irritating to the egregious. For us to be effective in our efforts to achieve social change, our responses to this range of manifestations must be measured and appropri-

ate. For me, as a 37-year-old physician to be called "girl" is insulting and demeaning. For a battered woman to be ignored by a police dispatcher simply because the violence is "domestic" is a crime.

I mentioned my daughter, but I also have a son. Thus, my perspectives on the issues of gender equality take on an added dimension. Parents set examples. I hope that my children see me as a positive, self-confident person with a sense of purpose and an ability to create my own opportunities. I hope that I help them develop a strong sense of justice and fairness. I hope that they learn the value of a measured response, but never turn their backs on the moral obligation to stand up against injustice, whether directed against them or against another. I hope that in my relationship with their father they see the importance of mutual respect.

I hope these things because my children's futures are inextricably caught up in how we as a society raise both our sons and our daughters. Real understanding about equality is hard to instill even in the most receptive adolescents and virtually impossible to impart to most adults. Yet if we emphasize to our children from a very young age that opportunities and talent should be gender blind, then we as a collective society will move forward towards the goal of true gender equality.

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photo by Margaret Lampert

Medical school was a life-changing experience for **Diane Avila Faran '90,** who came to HMS as a single parent with a 10-year-old daughter. Before medical school, her community was a predominantly Mexican section of Chicago, for whom she developed and conducted classes on women's health and sexuality, responsible relationships, and on survival skills such as applying for jobs and filing income taxes.

Though at one time she never would have pictured herself at Harvard Medical School— "It represented so much I was fighting against, the powerful them versus us"—she became a part of Harvard too. "I was as much a part of the Harvard community as anyone."

As a community educator in the mid to late 1970s for the Mujeres Latinas en Accion in Chicago, she helped others, particularly Latino women, gain a sense of control in their lives. This was a time when the women's movement had gained momentum; when *Our Bodies, Ourselves* had recently been published. She helped teenagers and others learn about their bodies and about how to negotiate the health care system. But lacking full confidence in herself, she needed the suggestion and support of a woman physician to convince her that she could and should be a physician.

She moved with her then five-year-old to California in 1979 to finish college courses at San Diego State University and was so determined to become a physician that she applied to 20 medical schools. Though she didn't think she had a chance to get in, she applied to HMS "because my roommate wanted a Harvard sweatshirt." On her interview at HMS she was amazed how much she liked it. "I had expected snooty, racist, elitist people and instead they were so warm and knowledgeable, I knew these were people I could emulate, people whom I could trust to teach me to be a doctor."

She was accepted in 1985, the year when a small group of students were to launch the experimental New Pathway with the Oliver Wendell Holmes Society. Not thinking too much about it, she checked a box saying she'd like to be part of it and was one of 25 students randomly selected. As it turns out, the New Pathway provided the more flexible hours that were perfect for someone trying to parent as well as study. The New Pathway was also a "nice accident" for her in that she really got to know her classmates, people very different ethnically and socioeconomically from her. "I began to see the real benefits of diversity."

But above all, the New Pathway encouraged in her the feeling that she could be a part of making her education what she wanted it to be. By the end of the first year, the eight women in the Oliver Wendell Holmes Society decided that they wanted to form an all-women tutorial. The administrators were against this initially; they felt that all the tutorials would benefit from the presence of women and that segragating them would be a step backwards. But they allowed Faran (who was Avila then) to represent the women's argument before an education committee. She was able to persuade them, in part by presenting videotapes of tutorials in which women tried to talk and were ignored by the others. As a result their all-women tutorial, guided by a woman tutor, was an "enlightening experience we wouldn't have gotten at any other school." No one person predominated the discussion: "It was a supportive, noncompetitive, environment and we deliberately did things we were weak at."

First year was tough, with financial and academic pressures, as well as difficulties helping her daughter get settled and adjusted to school. But friends who lived in Peabody Terrace became an extended family; when she had the one long clinical day per week, a classmate would pick up her daughter at school. And by the end of first year, with the friendship and support of Carola Eisenberg, then dean for student affairs, and staff from her office and the financial aid office, the system became a bit more flexible. Her daughter was given a pass to use the shuttle bus and library, and Eisenberg helped Faran maximize the grants and loans available to her.

Because her daughter came first, Faran acknowledges that there were opportunities she didn't take advantage of, such as classes in late afternoons and evenings, and the extent of her involvement was curtailed. But most of the time she was able to work things out with the support of family and friends. When she did a rotation that required her to take call, her mother would come out from Chicago and live with her. "My daughter ended up having a better life and in fact developed friendships with my classmates that she maintains today."

It took Faran an extra year to graduate because she spent summers juggling two or three part-time jobs. She managed to live with her daughter on a single student's budget.